GASE-P: Generic Assessment of Side Effects

Patient Version

Please rate whether you experienced one of the following complaints during the last seven days by using the scale below. Please indicate by circling yes or no whether you believe that these symptoms are related to your current medication**.**

0 = Complaint not present
1 = Mild: complaint causes mild distress or discomfort, but no impairment in daily functioning
2 = Moderate: complaint causes moderate distress or discomfort or at least some impairment in daily functioning
3 = Severe: complaint causes severe distress and discomfort, severe impairment in daily functioning, or acute danger to health

Please try to choose an answer even if you are not completely sure.

In the last seven days I had the following complaints:

Complaints	**Intensity** not present – mild – moderate - severe	Is this complaint related to your current medication?	
Headache	0-------1-------2-------3	O yes	O no
Hair loss	0-------1-------2-------3	O yes	O no
Dry mouth	0-------1-------2-------3	O yes	O no
Dizziness	0-------1-------2-------3	O yes	O no
Chest Pain	0-------1-------2-------3	O yes	O no
Palpitations, irregular heartbeat	0-------1-------2-------3	O yes	O no
Breathing problems	0-------1-------2-------3	O yes	O no
Low blood pressure, other circulation problems	0-------1-------2-------3	O yes	O no
Abdominal pain	0-------1-------2-------3	O yes	O no
Nausea	0-------1-------2-------3	O yes	O no
Vomiting	0-------1-------2-------3	O yes	O no
Constipation	0-------1-------2-------3	O yes	O no
Diarrhea	0-------1-------2-------3	O yes	O no
Reduced appetite	0-------1-------2-------3	O yes	O no
Increased appetite	0-------1-------2-------3	O yes	O no
Difficulty urinating	0-------1-------2-------3	O yes	O no
Problems with sexual performance or sex organs	0-------1-------2-------3	O yes	O no
Females: Painful or irregular menstruation	0-------1-------2-------3	O yes	O no
Skin Rash or Itching	0-------1-------2-------3	O yes	O no
Tendency to develop bruises	0-------1-------2-------3	O yes	O no
Fever, increased temperature	0-------1-------2-------3	O yes	O no
Abnormal sweating	0-------1-------2-------3	O yes	O no
Hot flashes	0-------1-------2-------3	O yes	O no
Convulsions or seizures	0-------1-------2-------3	O yes	O no

Fatigue, loss of energy	0-------1-------2-------3	O yes O no
Tremor	0-------1-------2-------3	O yes O no
Insomnia, sleeping problems	0-------1-------2-------3	O yes O no
Nightmares or abnormal dreams	0-------1-------2-------3	O yes O no
Back pain	0-------1-------2-------3	O yes O no
Muscle pain	0-------1-------2-------3	O yes O no
Joint pain	0-------1-------2-------3	O yes O no
Agitation	0-------1-------2-------3	O yes O no
Irritability, nervousness	0-------1-------2-------3	O yes O no
Depress-ed mood	0-------1-------2-------3	O yes O no
Thoughts about suicide	0-------1-------2-------3	O yes O no
Anxiety, Fearfulness	0-------1-------2-------3	O yes O no
Further symptoms: (please name these symptoms:)	0-------1-------2-------3 0-------1-------2-------3 0-------1-------2-------3	O yes O no O yes O no O yes O no