

Glasgow Antipsychotic Side-effect Scale for Clozapine

Please circle the number in the column that best indicates how often or how severely you have experienced the following side effects

Over the past week ...

	Never	Once	A few times	Every day	Check if severe or distressing.
I felt sleepy during the day	0	1	2	3	
I felt drugged or like a zombie	0	1	2	3	
I felt dizzy when I stood up or have fainted	0	1	2	3	
I have felt my heart beating unusually fast or irregularly	0	1	2	3	
I have experienced jerking limbs or muscles	0	1	2	3	
I have been drooling	0	1	2	3	
My vision has been blurry	0	1	2	3	
My mouth has been dry	0	1	2	3	
I have felt sick (nauseous) or have vomited	0	1	2	3	
I have felt gastric reflux or heartburn	0	1	2	3	
I have had problems opening my bowels (constipation)	0	1	2	3	
I have wet the bed	0	1	2	3	
I have been passing urine more often	0	1	2	3	
I have been thirsty	0	1	2	3	
I have felt more hungry than usual or have gained weight	0	1	2	3	
I have been having sexual problems	0	1	2	3	

Please write down any other side effects or physical problems you have experienced over the past week

Smoker: Y / N cigarettes/day Caffeine intake: cups/day Weight:

Has there been a recent change in your smoking habit? Increase/Decrease by cigarettes/day

Thank you!