Glasgow Antipsychotic Side-effect Scale (GASS)

Name: **Age:** **Sex: M / F**

Please list current medication and total daily doses below:

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects.
Also tick the **end or last** box if you found that the side effect was distressing for you.

Over the past week:	*Never*	*Once*	*A few times*	*Everyday*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. My muscles have been tense or jerky					
6. My hands or arms have been shaky					
7. My legs have felt restless and/or I couldn't sit still					
8. I have been drooling					
9. My movements or walking have been slower than usual					
10. I have had uncontrollable movements of my face or body					
11. My vision has been blurry					
12. My mouth has been dry					
13. I have had difficulty passing urine					
14. I have felt like I am going to be sick or have vomited					
15. I have wet the bed					
16. I have been very thirsty and/or passing urine frequently					
17. The areas around my nipples have been sore and swollen					
18. I have noticed fluid coming from my nipples					
19. I have had problems enjoying sex					
20. **Men only:** I have had problems getting an erection					

Tick yes or no** for the **last three months	*No*	*Yes*	*Tick this box if distressing*
21. **Women only**: I have noticed a change in my periods			
22. **Men and women**: I have been gaining weight			

Staff Information

1. Allow the patient to fill in the questionnaire themselves. All questions relate to the previous week.

2. Scoring

   For questions 1-20 award 1 point for the answer “once”, 2 points for the answer “a few times” and 3 points for the answer “everyday”.
   Please note zero points are awarded for an answer of “never”.

   For questions 21 and 22 award 3 points for a “yes” answer and 0 points for a “no”.

   Total for all questions=

3. For male and female patients a score of: 0-21 absent/mild side effects
   22-42 moderate side effects
   43-63 severe side effects

4. Side effects covered include: 1-2 sedation and CNS side effects
   3-4 cardiovascular side effects
   5-10 extra pyramidal side effects
   11-13 anticholinergic side effects
   14 gastro-intestinal side effects
   15 genitourinary side effects
   16 screening question for diabetes mellitus
   17-21 prolactinaemic side effects
   22 weight gain

The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user’s views and condition.