

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 see if you are suffering from 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 when you have had a side effect, please mark the end or last box between 1 – 10 to show how distressing that was for you.

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<i>Over the past <u>week</u>:</i>	<i>Never</i>	<i>Once</i>	<i>A few times</i>	<i>Everyday</i>	<i>Level of distress</i> 1 = not at all 10 = very much
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					

<i>Tick yes or no for the <u>last three months</u></i>	<i>No</i>	<i>Yes</i>	<i>Level of distress</i> 1 = not at all 10 = very much
21. Women only: I have noticed a change in my periods			
22. Men and women: I have been gaining weight			

Staff Information

1. Ask people to fill in the questionnaire themselves. All questions relate to the previous week.

2. **Scoring**

For questions 1 to 20 award the following:

- 1 point for the answer “once”
- 2 points for the answer “a few times”
- 3 points for the answer “everyday”.
- Zero points for an answer of “never”.

For questions 21 and 22 award the following:

- 3 points for “yes”
- 0 points for “no”

Total score for all questions = _____

3. For completed questionnaires (male & female), scores indicate the following side effect severity:

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 **level of distress** experienced with a particular side effect is not scored, but is intended to inform the clinician of the **person’s** views and condition.