Patient Self-Rating Form

Question	Answers
How have you been doing in the last month? Have you had problems keeping up with what you need to do for work, home, school or friends?	--- Yes, I have had problems If Yes what are they: --- No, I haven't had any problems
1 Since your last visit, have you been feeling depressed, sad, or down?	____ Yes, I have felt depressed, sad or down ____ No, I have not felt depressed, sad or down
2 Since your last visit, have you been feeling anxious, worried or nervous?	____ Yes, I have been feeling anxious, worried or nervous ____ No, I have not been feeling anxious, worried or nervous
3 Since your last visit, have you been thinking about death or have you had any feelings that you would be better off dead?	____ Yes, I have been thinking about death or I have felt that I would be better off dead ____ No, I have not been thinking about death and I have not had any feelings that I would be better off dead
4 Since your last visit, have you been feeling particularly good?	____ Yes, I have been feeling particularly good ____ No, I have not been feeling particularly good
5 Since your last visit, have you been feeling annoyed, angry, or resentful (whether you showed it or not)?	____ Yes, I have been feeling annoyed, angry or resentful ____ No, I have not been feeling annoyed, angry or resentful
6 Since your last visit, did you do anything that could have gotten you in trouble?	____ Yes, I have done something that could have gotten me in trouble ____ No, I have not done anything that could have gotten me into trouble

Since your last visit, please let us know if you have experienced any of the following. Please tell us about your experience whether you think that it was because of a medical problem, a medication side effect or other causes.

7 Have you felt dizzy or faint?	_____ Yes, I have felt dizzy or faint ____ No, I have not felt dizzy or faint
8 Have you had blurred vision?	_____ Yes, I have had blurred vision ____ No, I have not had any blurred vision
9 Have you had dry mouth?	_____ Yes, I have had dry mouth ____ No, I have not had dry mouth
10 Have you had too much saliva in your mouth or had drooling?	_____ Yes, I have had too much saliva or have had drooling ____ No, I have not had too much saliva and I have not had any drooling

11 Have you felt nauseous?	_____ Yes, I have felt nauseous ____ No, I have not had any nausea
12 Have you been constipated?	_____ Yes, I have had constipation ____ No, I have not had any constipation
13 Has your appetite for food been increased?	_____ Yes, my appetite for food has been increased ____ No, my appetite for food has not been increased
14 Have you gained weight?	_____ Yes, my weight has gone up ____ No, my weight has not gone up
15 Have you lost weight?	_____ Yes, I have lost weight ____ No, I have not lost weight
16 Have you felt restless or like you can't stay still?	_____ Yes, I have felt restless or have had difficulty staying still ____ No, I have not felt restless and I have not had any difficulty staying still
17 Any shaking of your hands, legs or other muscles?	_____ Yes, I have had shaking of my hands, legs or other muscles ____ No, I have not had any shaking
18 Any problems walking or moving or any problems feeling stiff or rigid?	_____ Yes, I had problems walking or moving or have had problems feeling stiff ____ No, I have not had any problems walking and I have not had any feelings of being stiff
19 Have your felt tired or fatigued?	_____ Yes, I have felt tired or fatigued ____ No, I have not felt tired or fatigued
20 Have you felt drowsy during the day?	_____ Yes, I have felt drowsy during the daytime ____ No, I have not felt drowsy during the daytime
21 Have you been sleeping too much at night?	_____ Yes, I sleep too many hours a night ____ No, I do not sleep too much at night
22 Have you been sleeping too little or had problems sleeping at night?	_____ Yes, I sleep too little or have had problems sleeping at night ____ No, I do not have any problems sleeping
23 Any decrease in your interest in sex?	_____ Yes, my interest in sex is low ____ No, my interest in sex is fine
24 Any other problems with sex?	_____ Yes, I have problems with sex ____ No, I do not have any problems with sex

25 Any problems with your breasts such as swelling or discharge?	_____ Yes, I have had problems with my breasts ____ No, I did not have any problems with my breasts
26 For women, any problems with your period?	_____ Yes, I have had problems with my period ____ No, I did not have any problems with my period
27 Are there other medical or side effect problems you wish to discuss with your prescriber?	____Yes, I have these problems (please list): ____No, I don't have any other medical or side effect problems
28 Since your last visit, how many days have you not taken your medication?	Number of days not taking medication _____ (if you have not missed any medication, please put 0 for number of days)
29 Have you had trouble remembering to take your medication?	___Yes, I have trouble remembering to take the medication ___No, I do not have trouble remembering to take the mediation
30 Do you find the number of medicines or the times when you are supposed to take them confusing or burdensome?	___Yes, the way I am supposed to take the medication is confusing or is burdensome to do ___No, the way I am supposed to take the medication is clear and is not a problem
31 Are you afraid of the medication?	___Yes, I am afraid of the medication ___No, I am not afraid of the medication
32 Do you think that you have an illness that requires taking medication?	___Yes, I have an illness that requires that I take medication ___No, I do not have an illness that requires that I take medication
33 Do you think that other people would think poorly of you if they knew that you take medication?	____Yes, taking medication might make other people think poorly of me ___No, taking medication would not make people think poorly of me
34 On average, how many cigarettes do you smoke per day?	Number of cigarettes I smoke per day___(if you do not smoke cigarettes, please put 0 for number of cigarettes smoked)
35 Since your last visit, did you drink any alcohol?	____ Yes, I have used alcohol ____No, I have not used any alcohol
36 Since your last visit, have you used any marijuana?	____ Yes, I have used marijuana ____No, I have not used any marijuana
37 Since your last visit, have you used any street drugs (other than marijuana)?	____ Yes, I have used street drugs other than marijuana. ____No, I have only used marijuana ____No, I have not used any street drugs including marijuana
38 Between now and your next visit, do you think we should keep your medication the same or consider changing the medications?	____ Consider changing ____ Stay the Same