Clozapine Questionnaire

Name:_____ Date:_____/_____/_____

This questionnaire is to be used by anyone taking clozapine or health professionals involved in supporting clozapine care and management. We hope that the last week/month has been a positive one for you.
Please answer honestly, circle yes even if the answer is only sometimes.

	These questions relate to possible side effects or health problems		Please circle	
1	Have your thoughts been as clear as usual this week/month?		Yes	No
	Have you or your carer noticed hallucinations (voices, smells, seeing images)?		Yes	No
	Have you been able to manage your home and/or finances this week/month?		Yes	No
	Have you had any thoughts that have worried you this week/month?		Yes	No
	Have you attended	an emergency department?	Yes	No
		been admitted to hospital?	Yes	No
		had extra visits to your GP or outpatients?	Yes	No

2	Have you increased or decreased how much tobacco you smoke?			Yes	No	Amt/day :
	Do you Vape?	Yes	No	Does your Vape Juice contain nicotine?	Yes	No	Amt/day :

3	What is your dose of clozapine?		mg	What time of day do you take the clozapine?		AM		PM
	Have you missed clozapine doses?						Yes	No
	Have you changed your dose of clozapine?	Yes	No	If yes from	mg	to		mg
	How many tablets / blister packs do you have left at home?						Blister Packs / Tablets	

4	Have you started, stopped or changed any medications including pain relief, medication prescribed by a doctor or anything over the counter from the pharmacy?	Yes	No
	Have you missed, decreased or increased your dose of any other prescribed medications?	Yes	No

5	Do you use any of the following substances?					
	coffee, cola or high energy drinks	Yes	No	alcohol	Yes	No
	other drugs such as meth / cocaine	Yes	No	cannabis	Yes	No
	If Yes has your usage of the substances changed?				Yes	No

6	Have you been physically unwell?	fever or increased sweating?	Yes	No
		cough or cold?	Yes	No
		nausea or vomiting	Yes	No

7	Have you felt dizziness when standing up, chest pain or shortness of breath?	Yes	No
8	Have you noticed any muscle stiffness, jumpy or jerky movements or tremors? (circle)	Yes	No
9	Have you felt more drowsy or sleepy than usual?	Yes	No
	Has your sleep pattern changed or your dreams become upsetting?	Yes	No
10	Have you had an increase or decrease in saliva or dribbling?	Yes	No

Constipation is a major side effect and brings a deal of risk to your general health and wellbeing.
Please turn over for specific bowel hygiene questions.

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11	Have your bowel movements changed?							Yes	No
	When was the last time you used your bowels?		Today	Yesterday	2-3 days ago	4-5 days ago	More than 5 days ago		
	How often do you usually go?								
	Using the **Bristol Stool Chart** below please circle the stool type that best describes your usual bowel motion.								
	Consistency			**Type 4**		Sausage or snake like, smooth and soft			
	Type 1		Separate hard lumps, like nuts (hard to pass)	**Type 5**		Soft blobs with clear-cut edges (easy to pass)			
	Type 2		Sausage-shaped, but lumpy	**Type 6**		Fluffy pieces with ragged edges, mushy			
	Type 3		Like a sausage, but with cracks on its surface	**Type 7**		Watery, no solid pieces (entirely liquid)			
	How do you manage constipation? (circle all applicable)								
	Strain and squeeze	drink more water	eat more fiber	exercise	Use stool softeners/ medications				
	If you use stool softeners/ medications what is the name of them?								
	Do you ever have blood in your stools?							Yes	No
	What describes best how your tummy usually feels?								
	soft	bloated	Occasional cramping	painful					
12	Has there been any change in the frequency in which you pass urine?							Yes	No
13	Have you had any sexual side effects that are bothering you?							Yes	No

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