Government of South Australia
SA Health
LHN

Clozapine Questionnaire

Name:______________________________ **Date**______________

This questionnaire can be used by anyone taking clozapine or clinicians involved in support or management

We hope that the last week/month has been a positive one for you.
The questions below cover possible side effects or health problems that are important to manage.
Answering honestly can help others understand how clozapine is working for you.

	Please circle yes or no		
1	Have your thoughts been as clear as usual this week/month?		Yes No
2	Have you been able to manage your home and/or finances this week/month?		Yes No
3	Have you had any thoughts that have worried you this week/month?		Yes No
4	Have you attended	an emergency department?	Yes No
		been admitted to hospital?	
		had extra visits to your GP or outpatients?	Yes No
5	Have you started or stopped any medications this week/month including any pain relief or anything purchased over the counter from the pharmacy?		Yes No
6	This week/month have you changed how much you use	cigarettes or tobacco?	Yes No
		cannabis?	Yes No
		alcohol?	Yes No
		other drugs?	Yes No
7	Have you made any changes to how much coffee, cola or high energy drinks you use?		Yes No
8	This week/month have you	missed clozapine doses?	Yes No
		decreased or increased your dose of clozapine?	Yes No
	How many tablets do you have left at home? ………………		
9	Have you missed, decreased or increased your dose of any other medications this week/month?		Yes No
10	Have you been unwell this week/month?	fever or increased sweating?	Yes No
		cough or cold?	Yes No
		nausea or vomiting?	Yes No
11	Have you had any dizziness, chest pain or shortness of breath this week/month?		Yes No
12	Has there been any change in the frequency in which you pass urine this week/month?		Yes No
13	Have you had any unexplained wetting (day or night) this week/month?		Yes No
14	Have you had any muscle stiffness or tremors this week/month?		Yes No
15	Have you felt more drowsy than usual this week/month?		Yes No
16	Have you had an increase or decrease in dribbling this week/month?		Yes No
17	Have you had any change in your bowel movements such as constipation or diarrhoea?		Yes No
	If yes what did do you do to try to fix this?		
18	This week/month have you had any changes to your sleeping pattern or have your dreams become upsetting?		Yes No

Do you have any other comments or questions? Please turn over if you need extra space to write.