

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### EVALUATION OF POSSIBLE MEDICATION SIDE EFFECTS

Please TICK any problems listed below that you have noticed in your child since the medication was started. The list is to help you think of possible effects. These effects may not be related to the medication, so please contact your clinician before changing or stopping the medication. Be prepared to discuss with your clinician when the effect **started** (and stopped, if it has), if any **other illnesses** were occurring at that time, and **all other medications** your child was taking at this time.

<p><b><u>Visual</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurriness</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Irritation or redness</li> <li><input type="checkbox"/> Eye pain</li> <li><input type="checkbox"/> Watering</li> <li><input type="checkbox"/> Eye twitching</li> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Light bothering eyes</li> </ul>	<p><b><u>Hearing</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ear ache</li> <li><input type="checkbox"/> Ear infection</li> <li><input type="checkbox"/> Poor hearing</li> <li><input type="checkbox"/> Ringing in the ears</li> </ul>	<p><b><u>Nose</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Nose dryness</li> <li><input type="checkbox"/> Sinus congestion</li> <li><input type="checkbox"/> Change in smell</li> </ul>
<p><b><u>Mouth/Lips</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mouth ulcer/sores</li> <li><input type="checkbox"/> Dry mouth</li> <li><input type="checkbox"/> Gum problems</li> <li><input type="checkbox"/> Too much saliva</li> <li><input type="checkbox"/> Dental problems</li> <li><input type="checkbox"/> Drooling</li> <li><input type="checkbox"/> Sore/swollen tongue</li> <li><input type="checkbox"/> Bad taste in mouth</li> </ul>	<p><b><u>Head</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Facial Pain</li> <li><input type="checkbox"/> Face Muscle Weakness</li> </ul>	<p><b><u>Throat</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Hoarse voice/laryngitis</li> <li><input type="checkbox"/> Difficulty swallowing</li> </ul>
<p><b><u>Stomach</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain/Discomfort</li> <li><input type="checkbox"/> Heartburn/Reflux</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Vomiting</li> </ul>	<p><b><u>Chest</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Tightness</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Coughing</li> </ul>	<p><b><u>Breast</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Swelling</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Discharge</li> </ul>
<p><b><u>Bowels</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Stool discoloration</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Bloating/gassy</li> </ul>	<p><b><u>Appetite</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Increased appetite</li> <li><input type="checkbox"/> Decreased appetite</li> <li><input type="checkbox"/> Taste abnormality</li> <li><input type="checkbox"/> Weight gain (___lbs)</li> <li><input type="checkbox"/> Weight loss (___lbs)</li> <li><input type="checkbox"/> Increased thirst</li> </ul>	<p><b><u>Heart</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rapid heartbeat</li> <li><input type="checkbox"/> Irregular heartbeat</li> <li><input type="checkbox"/> Slow heartbeat</li> </ul>
<p><b><u>Menstrual</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Irregular periods</li> <li><input type="checkbox"/> Mid-cycle pain</li> <li><input type="checkbox"/> Cramping</li> <li><input type="checkbox"/> Premenstrual tension or mood changes</li> <li><input type="checkbox"/> Increased bleeding</li> <li><input type="checkbox"/> Breakthrough bleeding</li> </ul>	<p><b><u>Genital</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Genital discomfort/swelling</li> <li><input type="checkbox"/> Decreased urges/interest in Sex</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Sexual dysfunction</li> <li><input type="checkbox"/> Increased urges/Interest in sex</li> </ul>	<p><b><u>Urination</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Painful</li> <li><input type="checkbox"/> Difficulty</li> <li><input type="checkbox"/> Increase urination</li> <li><input type="checkbox"/> Bedtime wetting</li> <li><input type="checkbox"/> Daytime wetting</li> <li><input type="checkbox"/> Change in color/smell</li> </ul>
		<p><b><u>Muscles, Bones, Joints</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Swelling/fluid buildup</li> <li><input type="checkbox"/> Tingling</li> <li><input type="checkbox"/> Cramps/contractions</li> <li><input type="checkbox"/> Restless legs</li> </ul>

<p><b><u>Movement</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Clumsiness/poor coordination</li> <li><input type="checkbox"/> Restlessness</li> <li><input type="checkbox"/> Tics (twitches, blinking, making sounds)</li> <li><input type="checkbox"/> Tremor, trembling or shaking</li> <li><input type="checkbox"/> Rigidity, aches, cramps</li> </ul>	<p><b><u>Sleep</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulty falling asleep</li> <li><input type="checkbox"/> Sleeping too much</li> <li><input type="checkbox"/> Interrupted sleep</li> <li><input type="checkbox"/> Awakening not feeling rested</li> <li><input type="checkbox"/> Early morning awakening</li> <li><input type="checkbox"/> Drowsiness</li> <li><input type="checkbox"/> Nightmares</li> </ul>	<p><b><u>Energy</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tiredness/fatigue</li> <li><input type="checkbox"/> Excessive yawning</li> <li><input type="checkbox"/> Sedation/drugged feeling</li> <li><input type="checkbox"/> Overly excited/energetic</li> <li><input type="checkbox"/> Withdrawn</li> <li><input type="checkbox"/> Staring</li> <li><input type="checkbox"/> Too keyed up/unable to settle down</li> </ul>
<p><b><u>Skin/Hair</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rashes/irritation</li> <li><input type="checkbox"/> Flaking scalp</li> <li><input type="checkbox"/> Change in body odor</li> <li><input type="checkbox"/> Pimples/acne</li> <li><input type="checkbox"/> Sensitive to Sun</li> <li><input type="checkbox"/> Hair Problems (loss, brittle)</li> <li><input type="checkbox"/> Hives                    <input type="checkbox"/> Blisters</li> <li><input type="checkbox"/> Oily skin/hair    <input type="checkbox"/> Dry Skin</li> <li><input type="checkbox"/> Excessive Sweating</li> <li><input type="checkbox"/> Easy Bruising</li> </ul>	<p><b><u>Strange Experiences/Thoughts</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seeing things that are not there</li> <li><input type="checkbox"/> Hearing things that are not there</li> <li><input type="checkbox"/> Smelling/tasting things that are not there</li> <li><input type="checkbox"/> Strange physical feelings</li> <li><input type="checkbox"/> Strange thoughts or ideas</li> </ul>	<p><b><u>Thinking</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Memory problems</li> <li><input type="checkbox"/> Speech difficulty/changes</li> <li><input type="checkbox"/> Concentration difficulty</li> <li><input type="checkbox"/> Dizziness/faintness</li> <li><input type="checkbox"/> Confusion</li> <li><input type="checkbox"/> Slowed thinking</li> <li><input type="checkbox"/> Loss of consciousness</li> </ul>
<p><b><u>Mood Changes</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depressed</li> <li><input type="checkbox"/> Irritable</li> <li><input type="checkbox"/> Anxious/nervous</li> <li><input type="checkbox"/> "Manicky"</li> <li><input type="checkbox"/> Loss of Interest/motivation</li> </ul>	<p><b><u>Accident/Injury</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Accidental injury (describe)</li> <li><input type="checkbox"/> Attempted suicide</li> <li><input type="checkbox"/> Self-harmful behavior (cutting on self, banging head, etc)</li> </ul>	<p><b><u>Illness</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Upper respiratory infection</li> <li><input type="checkbox"/> Lower respiratory infection</li> <li><input type="checkbox"/> Bacterial infection</li> <li><input type="checkbox"/> Swollen glands</li> <li><input type="checkbox"/> Urinary tract infection</li> <li><input type="checkbox"/> Feeling flushed or warm</li> <li><input type="checkbox"/> (Other) fever</li> <li><input type="checkbox"/> Feeling cold or chills</li> <li><input type="checkbox"/> Gastrointestinal virus</li> <li><input type="checkbox"/> Allergies/asthma</li> </ul>

Medical or Surgical Procedure (describe): \_\_\_\_\_

Medicine (s) (names/doses of all medications currently taking): \_\_\_\_\_

ANY OTHER SIDE EFFECTS (Please Describe): \_\_\_\_\_

(adapted by J. Bostic, M.D., Ed.D.)

This document is intended to provide general educational information concerning mental health and health care resources. This information is not an attempt to practice medicine or to provide specific medical advice, and should not be used to make a diagnosis or to replace or overrule a qualified health care provider's judgment. The reader is advised to exercise judgment when making decisions and to consult with a qualified health care professional with respect to individual situations and for answers to personal questions. Material in this document is protected by copyright law. Users may print this document for personal, non-commercial use only, provided they identify the source of the material and include a statement that the materials are protected by copyright law.

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