Vancouver Coastal Health

Community Mental Health Services
Lions Gate Hospital
HOpe Center
1337 St. Andrews Avenue
North Vancouver BC V7L 0B8

ADHD MEDICATION SIDE EFFECTS MONITORING SHEET

Have you had any of the following side effects over the last 1 to 2 weeks?
**Please circle the side effect of concern when given several options e.g. dry eyes / mouth / skin.

NAME:_____ DATE:_____ Medication name:_____ Dose: _____

Other psychiatric medication:_____ Dose: _____

Side Effect	Never	Sometimes		Often		Always
Headache	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Dizziness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Thirst	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Rash	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sweating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Dry Mouth / Eyes / Skin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Acne	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Increase / Decrease appetite	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Weight Loss / Gain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Stomach ache	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Nausea / Vomiting	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Urination Difficulty / Frequency	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Tics	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Restlessness /Agitation	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Have to keep moving	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Irritability	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anger	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sadness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Fearful /Anxious	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Mood instability / Rapid mood changes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Mood change when medication wears off (rebound)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep difficulty	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sexual functioning issues	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Suicidal ideation	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Check the box beside the words that best describe your overall level of functioning since your last visit:

☐ Much worse ☐ A little worse ☐ No change ☐ A little better ☐ Much better

Clinician Comments: Vital Signs: BP: Pulse:_____

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