THE UNIVERSITY OF WESTERN AUSTRALIA

My Medicines & Me Questionnaire (M3Q)

A side effect questionnaire for mental health medications

List any medications you are currently taking:

(Include all prescription, over-the-counter medications and natural therapies)

Drug:	Dose:

Consumer name: _____

Clinic attended: _____

To be completed in the clinic.

Reviewed by: _____

Comments:

Date: _____ Identification number: _____

Side effects

Mental health consumers can experience many benefits from their prescribed medications. However, they can also experience adverse side effects. Please go through this list and only tick the boxes if you have experienced the following side effect to any degree **IN THE PAST FOUR WEEKS**.

General health	
Have you felt weak?	☐
Have you felt drugged or like a zombie?	☐
Have you been sweating more than usual?	☐
Sleep related issues	
Have you felt tired during the day?	☐
Have you had difficulty staying awake during the day?	☐
Have you had difficulties waking up fresh in the morning?	☐
Weight and appetite changes	
Have you gained weight?	☐
Do you think some foods taste different/odd?	☐
Have you felt more hungry than usual?	☐
Have you been more thirsty than usual?	☐
Bowel and bladder habits	
Have your stools been hard or difficult to pass?	☐
Have you needed to go to the toilet often?	☐

Skin changes	
Has your skin been more sensitive to the sun?	☐
Have you noticed any areas of darker skin?	☐
Diabetes	
Do you have diabetes?	☐
Have you been told that your blood sugar levels are high?	☐
Have you noticed a change in your blood sugar levels?	☐
Visual problems	
Has your vision been blurry?	☐
Have your eyes felt dry and gritty?	☐
Oral problems	
Have you found that your words don't come out clearly?	☐
Have you found it difficult to swallow?	☐
Mood	
Have you felt anxious?	☐
Have you felt agitated?	☐
Have you felt sad?	☐
Have you lost interest in enjoyable things?	☐
Uncontrollable face and body movements	
Have you experienced fits/jerks?	☐
Have your arms or legs been shaky?	☐
Have you had restless legs?	☐

Sexual health	
Have you been less interested in sex?	☐
Have you found it difficult to enjoy sex?	☐
Have you been unable to reach orgasm?	☐
Have the areas around your nipple been sore and/or swollen?	☐

In the last 4 weeks, have you experienced any side effects that have not been listed?

From the side effects you have identified above please rank up to 3 that are your most bothersome

(1 being the most bothersome and 3 being the least bothersome)

#1	
#2	
#3	

SIDE EFFECT SPECIFIC QUESTIONS

Please elaborate on the three most bothersome side effects you listed on the previous page.

Side Effect #1	

1. How often do you experience this side effect?

☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____

How long does it last?

_____

_____

2. Do you know what medication may be causing this side effect?

☐ No

☐ Yes → Which medication:

_____

3. How does it impact your daily living?

(eg: Prevents you from being in public places, going to work, participating in activities)

_____

_____

_____

4. Do you think other people are aware of this side effect?

☐ No

☐ Yes → Please explain: (What do they do or say to make you feel this way?)

_____

_____

_____

SIDE EFFECT SPECIFIC QUESTIONS

Side Effect #2	

1. **How often do you experience this side effect?**

☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____

How long does it last?

_____

_____

2. **Do you know what medication may be causing this side effect?**

☐ No

☐ Yes → Which medication:

_____

3. **How does it impact your daily living?**

(eg: Prevents you from being in public places, going to work, participating in activities)

_____

_____

_____

4. **Do you think other people are aware of this side effect?**

☐ No

☐ Yes → Please explain: (What do they do or say to make you feel this way?)

_____

_____

_____

SIDE EFFECT SPECIFIC QUESTIONS

Side Effect #3	

1. **How often do you experience this side effect?**

   ☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____

   How long does it last?

   _____

   _____

2. **Do you know what medication may be causing this side effect?**

   ☐ No

   ☐ Yes → Which medication:

   _____

3. **How does it impact your daily living?**

   (eg: Prevents you from being in public places, going to work, participating in activities)

   _____

   _____

   _____

4. **Do you think other people are aware of this side effect?**

   ☐ No

   ☐ Yes → Please explain: (What do they do or say to make you feel this way?)

   _____

   _____

   _____

GENERAL QUESTIONS

1. **Have you ever considered not taking your medication due to the severity of the side effects?**

☐ No

☐ Yes → How often? ☐ Often _____

☐ Sometimes _____

Which side effects in particular?

_____

Have you ever actually stopped taking your medication?

☐ No

☐ Yes → Why?

_____

_____

2. **Medications have benefits. What benefits do you gain by taking your medication?**

_____

_____

_____

_____

3. **Is there anything else you would like to tell me regarding your medications?**

_____

_____

_____

_____