



THE UNIVERSITY OF
WESTERN AUSTRALIA

My Medicines & Me Questionnaire (M3Q)

A side effect questionnaire for mental health medications

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

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

Sexual health	
Have you been less interested in sex?	<input type="checkbox"/>
Have you found it difficult to enjoy sex?	<input type="checkbox"/>
Have you been unable to reach orgasm?	<input type="checkbox"/>
Have the areas around your nipple been sore and/or swollen?	<input type="checkbox"/>

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	
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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	
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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	
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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?
