




**Pittsburgh Anticholinergic Symptom Scale – Patient Assessment Form (PASS Version 2.0)**

**How often do you have these symptoms?**

*Think about the past week. Circle a number.*

	NOT AT ALL 		HALF THE WEEK 			EVERY DAY 	
<b>Dry mouth</b>	0	1	2	3	4	5	6
<b>Blurred vision</b>	0	1	2	3	4	5	6
<b>Fast heartbeat</b>	0	1	2	3	4	5	6
<b>Difficulty urinating</b>	0	1	2	3	4	5	6
<b>Constipation</b>	0	1	2	3	4	5	6
<b>Confusion or memory problems</b>	0	1	2	3	4	5	6
<b>How intense (severe) have these side effects been?</b>	None 0	Trivial 1	Mild 2	Moderate 3	Marked 4	Severe 5	Intolerable 6
<b>How much have these side effects interfered with your day to day functioning?</b>	None 0	Minimal 1	Mild 2	Moderate 3	Marked 4	Severe 5	Unable to function 6

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