### Severity Of Symptoms Scale (SOSS)

**Initials** | **ID #** | **Date** | **Visit** | **Age** | **Marital Status** | **Gender** | **Race or Ethnic Origin** | **Protocol Number**
---|---|---|---|---|---|---|---|---

- **Severity of Symptoms**
  1. dry mouth
  2. sweating
  3. trembling
  4. nausea
  5. constipation
  6. diarrhea
  7. blurred vision
  8. headaches
  9. drowsiness
  10. heart racing or pounding
  11. poor sleep
  12. tingling or numbness
  13. unsteadiness
  14. forgetfulness
  15. ringing in your ears
  16. poor concentration
  17. dizziness
  18. delayed urination
  19. frequent urination
  20. weight gain
  21. nightmares
  22. difficulty achieving orgasm
  23. difficulty with sexual arousal
  24. muscle twitching or clenching
  25. spasms or drawing of muscles
  26. uncomfortable urge to move about
  27. bad taste in mouth
  28. swelling (hands, feet, face, etc.)
  29. thirst
  30. rash
  31. other skin problems
  32. increased appetite
  33. others
  34. others

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