

Online Supplementary Material

Morris DW, Budhwar N, Husain M, et al. Depression treatment in patients with general medical conditions: results from the CO-MED trial. *Ann Fam Med*. 2012;10(1):23-33.

<http://www.annfammed.org/content/10/1/23/suppl/DC1>

Supplemental Appendix 1. Frequency and Intensity of Burden of Side Effects Rating (FIBSER)

Name/ID: _____

Date: _____

INSTRUCTIONS: Select the best response for the following 3 questions.

- Choose the response that best describes the frequency (how often) of the side effects of the medication you have taken within the past week for your depression. Do not rate side effects if you believe they are due to treatments that you are taking for medical conditions other than depression. Rate the frequency of these side effects for the past week.

No side effects	Present 10% of the time	Present 25% of the time	Present 50% of the time	Present 75% of the time	Present 90% of the time	Present all of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

- Choose the response that best describes the intensity (how severe) of the side effects that you believe are due to the medication you have taken within the last week for your depression. Rate the intensity of the side effect(s), when they occurred, over the last week.

No side effects	Trivial	Mild	Moderate	Marked	Severe	Intolerable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

- Choose the response that best describes the degree to which antidepressant medication side effects that you have had over the last week have interfered with your day to day functions.

No impairment	Minimal impairment	Mild impairment	Moderate impairment	Marked impairment	Severe impairment	Unable to function due to side effects
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6