

**Premenstrual Syndrome Questionnaire**  
**(all female patients, when applicable)**

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Present Contraception:  none       pill       IUD       other

History of Oral contraceptive pills:  yes       no      Number of years: \_\_\_\_\_

Please rate the following symptoms according to the degree of severity, and indicate when in your cycle you experience them.

	1- Mild	2- Moderate	3- Severe	Week before period	Week after period	Other
<b>PMS-A</b>						
Anxiety	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous tension	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PMS-C</b>						
Appetite increase	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PMS-D</b>						
Depression	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PMS-H</b>						
Fluid retention	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen extremities	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal bloating	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1- Mild	2- Moderate	3- Severe	Week before period	Week after period	Other
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**Other symptoms**

Oily skin	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backache	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain radiates down thighs	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During first two days of period**

Menstrual cramps	1	2	3
Backache	1	2	3