

Premenstrual Syndrome Questionnaire

 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
PMS-A						
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"/>
PMS-C						
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"/>
PMS-D						
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"/>
PMS-H						
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
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			