**PREMENSTRUAL SYNDROME QUESTIONNAIRE**

Full patient name: _____

Date: _____ Age: _____ Height: _____ Weight: _____

Present contraception: ◯ None ◯ Pill ◯ IUD ◯ Other

History of contraceptive pills: ◯ Yes ◯ No Number of years : _____

**Please rate the following symptoms according to the degree of severity with which you experience them. Please also indicate when you experience symptoms.**

| **1 = Mild** | **2 = Moderate** | | **3 = Severe** | **week before period** | **week after period** | **other** |
|---|---|---|---|---|---|---|
| **PMS –A** | **(circle one)** | | | | **(tick one)** | |
| Anxiety | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Irritability | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Mood swings | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Nervous tension | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| **PMS – C** | | | | | | |
| Appetite increase | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Headache | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Fatigue | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Dizziness or fainting | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Palpitations | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| **PMS – D** | | | | | | |
| Depression | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Crying | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Forgetfulness | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Confusion | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Insomnia | 1 | 2 | 3 | ◯ | ◯ | ◯ |

| **1 = Mild** | **2 = Moderate** | | **3 = Severe** | **week before period** | **week after period** | **other** |
|---|---|---|---|---|---|---|
| **PMS – H** | **(circle one)** | | | | **(tick one)** | |
| Fluid retention | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Weight gain | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Swollen extremities | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Breast tenderness | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Abdominal bloating | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| **Other Symptoms** | | | | | | |
| Oily skin | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Acne | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Constipation | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Diarrhoea | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Backache | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Hives | 1 | 2 | 3 | ◯ | ◯ | ◯ |
| Weakness & radiation down thighs | 1 | 2 | 3 | ◯ | ◯ | ◯ |