PREMENSTRUAL SYNDROME QUESTIONNAIRE

Full Patient Name: _____

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

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

0 = None 1 = Mild 2 = Moderate 3 = Severe

PMS - 1	Circle One			
Anxiety	0	1	2	3
Irritability	0	1	2	3
Mood Swings	0	1	2	3
Nervous Tension	0	1	2	3
Suspiciousness	0	1	2	3

PMS - 2				
Appetite Increase	0	1	2	3
Headache	0	1	2	3
Fatigue	0	1	2	3
Dizziness or Fainting	0	1	2	3
Palpitations	0	1	2	3

PMS - 3				
Depression	0	1	2	3
Crying	0	1	2	3
Forgetfulness	0	1	2	3
Confusion	0	1	2	3
Insomnia	0	1	2	3

PMS – 4	Circle One			
Fluid Retention	0	1	2	3
Weight Gain	0	1	2	3
Swollen Extremities	0	1	2	3
Breast Tenderness	0	1	2	3
Abdominal Bloating	0	1	2	3

Other Symptoms				
Oily Skin	0	1	2	3
Acne	0	1	2	3
Constipation	0	1	2	3
Diarrhea	0	1	2	3
Backache	0	1	2	3
Hives	0	1	2	3
Weakness & Radiation Down Thighs	0	1	2	3

Add all items for Total Score:

Total Score _____