Regional Clinics
Obstetric & Gynecology

PMS SCREENING QUESTIONNAIRE

Name _____ Age _____ Today's Date _____ / _____ / _____

In the following table, please indicate which of these symptoms you experience at least 4 days before your menstrual period. In addition, only list symptoms that are then relieved within the first couple of days of your period and that have been present in at least 3 out of the past 6 cycles.

Please indicate the severity of symptoms as follows:

0 = none
1 = mild, does not interfere with activities
2 = moderate, interferes with activities but is not disabling
3 = severe, disabling

Also, list the number of days that each symptom is present.

SYMPTOM	SEVERITY	# DAYS
I feel depressed or hopeless		
I have headaches		
I feel tearful or cry easily		
I feel "on edge", angry, irritable, anxious or "wired"		
I have decreased interest in my usual activities		
I have difficulty concentrating		
I feel easily fatigued; I lack energy		
I have food cravings (salt, foods high in sugar or chocolate)		
I have trouble sleeping or sleep more than usual		
I feel overwhelmed or out of control		
I have breast tenderness		
I have a sensation of bloating or temporary weight gain		