## **PMS Symptom Chart**

| Cycle start date: |  |
|-------------------|--|
|                   |  |

## Daily, please indicate the severity of symptoms as follows:

0 = None/Not applicable

- 1 = Mild, does not interfere with activities
- 2 = Moderate, interferes with activities but is not disabling
- 3 = Severe, disabling

Please record menstrual flow using the following descriptions if they apply:

H=heavy, M=medium, L=low, B=brown spotting

First day of cycle is first day of bleeding

| Day of Cycle  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 2 | 22 | 23 2 | 24 | 25 | 26 2 | 7 28 | 3 29 | 30 | 31 | 32 | 33 | 34 : | 35 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|------|----|------|----|----|------|------|------|----|----|----|----|------|----|
| MENSTRUAL FLOW (H, M, L, B)                             |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I feel depressed or hopeless                            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I feel tearful or cry easily                            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I feel "on edge", angry, irritable, anxious or "wired"  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I feel overwhelmed or out of control                    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I have decreased interest in my usual activities        |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      | П  |
| I have difficulfy concentrating                         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I feel easily fatigued; lack energy                     |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      | П. |
| I have food cravings (salt, high in sugar, chocolate)   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I have trouble sleeping                                 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I sleep more than usual                                 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I have headaches  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I have breast tenderness                                |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
| I have a sensation of bloating or temporary weight gain |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |      |    |      |    |    |      |      |      |    |    |    |    |      |    |
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| Rx Log:                    |   |   |   |   |   |          |   |   |   |    |    |          |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |                     | _ |
| Medication, Qty, Frequency | 1 | 2 | 3 | 4 | 5 | 6        | 7 | 8 | 9 | 10 | 11 | 12       | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34                  | 3 |
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| Other Notes                | 1 | 2 | 3 | 4 | 5 | 6        | 7 | 8 | 9 | 10 | 11 | 12       | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34                  | 3 |
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