

# PMDD Test

<b>Name:</b>		<b>DoB:</b>	<b>Age:</b>
<b>Gender:</b>	<b>Date:</b>	<b>Physician's Name:</b>	

## Diet and Lifestyle

Guide Questions: Do you drink alcoholic beverages, smoke, or are overweight? Please briefly describe your diet and lifestyle - the food you eat, how often you exercise, how you manage stress, etc.

## Medical History

Guide Questions: Does your family have a history of PMS or PMDD? Do you or your family have a history of mood disorders/mental health problems like depression, or postpartum depression?

Have you taken a physical exam (including a pelvic exam)?  Yes  No

Have you done other tests that check your thyroid levels, blood, estrogen/progesterone levels,  Yes  No

Other: .....

Any other diagnoses/conditions/concerns you think we should know about?

## Personal Strengths

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Depressed mood           | <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Food cravings                  |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Mood swings       | <input type="checkbox"/> A feeling of a lack of control |
| <input type="checkbox"/> Irritability             | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> Trouble                  | <input type="checkbox"/> Severe fatigue    | <input type="checkbox"/> Swelling                       |
| <input type="checkbox"/> Sleeping/Insomnia        | <input type="checkbox"/> Forgetful         | <input type="checkbox"/> Anger                          |
| <input type="checkbox"/> Hypersomnia              | <input type="checkbox"/> Aches             | <input type="checkbox"/> Cramps                         |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Confusion                      |

Other:

## Symptom Chart

Start Date (First Day of Menses): .....

End Date: .....

### Symptom Scoring:

- 1 Minimal; Slightly apparent
- 2 Mild; Aware of symptoms but doesn't affect daily routine
- 3 Moderate; Bothered by symptoms/interferes with your daily routine
- 4 Severe; Overwhelming symptoms/unable to carry out daily routine

**Instructions:** Write down the symptoms you're experiencing - you may refer to the checklist you answered - and score them daily according to the Symptom Scoring table above.

Symptoms	Days														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Symptoms	Days														
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30