PMDD Test

Name:		DoB:	Age:
Gender:	Date:	Physician's Name:	

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

- ☐ Depressed mood
- ☐ Anxiety
- ☐ Irritability
- ☐ Trouble
- ☐ Sleeping/Insomnia
- ☐ Hypersomnia
- ☐ Difficulty concentrating
- ☐ Nervousness
- ☐ Mood swings
- ☐ Poor coordination
- ☐ Severe fatigue
- ☐ Forgetful
- ☐ Aches
- ☐ Breast tenderness
- ☐ Food cravings
- ☐ A feeling of a lack of control
- ☐ Headaches
- ☐ Swelling
- ☐ Anger
- ☐ Cramps
- ☐ 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