PMDD Test

Name: _____ DoB: _____ dd / mm / yyyy

Age: _____ Gender: _____

Date: _____ dd / mm / yyyy 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?

SYMPTOMS

Symptoms

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

Other:

SYMPTOM CHART

Start Date (First Day of Menses): _____ dd / mm / yyyy **End Date:** _____ dd / mm / yyyy

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.