MONTH: _____

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	22	23	24	25	26	27	28	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																																			
I have difficulty concentrating																																			
I feel easily fatigued; I lack energy																																			
I have food cravings (salt, foods high in sugar, chocolate)																																			
I have trouble sleeping or sleep more than usual																																			
I have headaches																																			
I have breast tenderness																																			
I have a sensation of bloating or temporary weight gain																																			