Name & Month:

Indicate daily severity of symptoms:

0 = None/Not applicable
1 = Mild, does not interfere with activities
2 = Moderate, interferes with activities but is not disabling
3 = Severe, disabling

Choose from symptoms below and enter into column below

Irritability	Depression
Cry easily	Anxiety
Breast Tenderness	Angry
Bloating	Fatigue
Weight Gain	Headache
CHO Cravings	Insomnia

Record menstrual flow using the following

(Day 1=First day of mentrual cycle)

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
DATE																																			
MENSTRUAL FLOW (H, M, L, B)																																			
H=heavy, M=medium, L=low, B=brown spotting																																			
Enter your symptoms that matter most below																																			