Saint Pope Paul VI Institute

Cyclic Symptoms Questionaire

Spreadsheet created by Dunwoody FertilityCare

Name: **Month:**

Please indicate, on a daily basis, the severity of symptoms as follows:

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

Please record menstrual flow using the following descriptions if they apply:

H = Heavy; M = Moderate; L = Light; B = Brown

Mark your Peak Day (P)																																				
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, VL, B)																																			
I feel "on edge", angry, irritable																																			
I feel overwhelmed or out of control																																			
I feel anxious or "wired"																																			
I have breast tenderness																																			
I have a sensation of bloating																																			
I have weight gain																																			
I have food cravings (salt/high sugar/chocolate)																																			
I feel tearful or cry easily																																			
I feel depressed or hopeless																																			
I have decreased interest in my usual activities																																			
I have headaches																																			
I feel easily fatigued; I lack energy																																			
I have difficulty concentrating																																			
I have Cramps/Pain																																			