


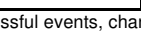


# Menstrual Cycle Symptom Diary

Please fill in this form daily, placing a cross in the box for each symptom experienced that day.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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	36	37	38	39	40						
Date:																																														
<b>mood and brain</b>																																														
Depression, feeling down																																														
Anxious, nervous, worrying																																														
Mood swings - irritable, teary, easily upset																																														
Difficulty concentrating, poor memory																																														
Poor sleep, broken sleep, insomnia, oversleeping																																														
<b>physical</b>																																														
Fatigue, tiredness, lack of motivation																																														
Digestive upset, diarrhoea, constipation, bloating																																														
Abdominal pain, back pain																																														
Skin changes, rashes, pimples																																														
Increased or decreased appetite, overeating, cravings																																														
Headaches																																														
Hot flushes, night sweats																																														
Breast swelling/tenderness/pain																																														
Fluid retention																																														
Note: Take saliva/urine samples today																																														
<b>menses</b>																																														
Bleeding																																														
Pain, cramping																																														
Sensation of dragging, heaviness in the pelvis																																														
Presence of clots																																														
<b>Mark down the number of pads or tampons used daily next</b>																																														
Pads																																														
																																														
Tampons																																														
																																														
Please note any change in circumstances: Stressful events, changes in health, medications, any other symptoms (note with date of occurrence)																																														