



**PREMENSTRUAL AND MENSTRUAL SYNDROME HEALTH ANALYSIS
QUESTIONNAIRE**

Name: _____

Date: _____ Age: _____ Height: _____ Weight: _____

MENSTRUAL HISTORY:

1. Age of First period.....

2. Do you have regular periods (Y/N).....

3. Regular intervals between periods

- ☐ Less than 24 days
- ☐ 24-26 days
- ☐ 27-29 days
- ☐ 30-32 days
- ☐ 33-35 days
- ☐ More than 35 days

4. How heavy is your menstrual period usually?

- ☐ Light
- ☐ Moderate
- ☐ Heavy

5. How long is your period duration (in days)? please circle on the number.

1 2 3 4 5 6 7 8

Kindly rate the following symptoms according to the degree of your severity. Please indicate when you experience these symptoms

0 = None 1 = Mild 2 = Moderate 3 = Severe

FILL THE SEVERITY LEVEL (0, 1, 2, 3) (TICK WHICH ONE IS APPLICABLE)

SEVERITY BEFORE PERIOD DURING PERIOD

CLASS A

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Anger or Irritability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Mood swings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Restlessness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SRI RAMAKRISHNA ENGINEERING COLLEGE, COIMBATORE-641022
&
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CLASS B

- | | | | |
|---------------------------|--------------------------|--------------------------|--------------------------|
| 6. Tension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Confusion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Forgetfulness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Difficulty in sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Depression(hopeless) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CLASS C

- | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|
| 11. Appetite Increase | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Headache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Fainting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Abdominal pain/Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CLASS D

- | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|
| 16. Swollen Extremities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Breast Tenderness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Abdominal Bloating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Weight Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Fluid Retention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ANY OTHER SYMPTOMS:



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6. Have menstrual problems ever interfered with your work responsibilities? (Y/N)

7. Have you experienced any cramps? ☐ Before periods ☐ During periods

8. How often have you had pelvic pain with your periods? please circle on the number.

1. Occasionally 2. Often 3. Always

9. Have you taken any pain killers prescribed by doctor in the last 3 months? (Y/N).....

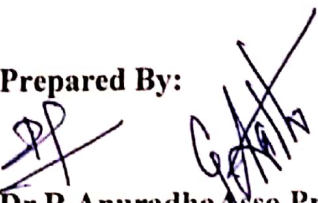
10. Do you practice any Yoga or Meditation (Y/N).....

If yes, name of the technique

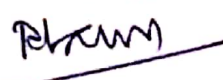
Duration of Practising

Candidate Signature _____

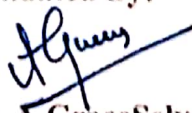
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