THE "SHE" SCALE

Did one or more of the following symptoms/complaints applied to you during the last month and if so, how frequent, severe, intense, or strong was it?
Please, mark the appropriate box for each symptom. If something do not apply for you, e.g. if you have no menstrual bleeding, you do not answer "Yes" or "No" (leave it free) and mark "NB" (=no bleeding).
Please check <u>each</u> line.

Complaints or symptoms		Applied to me (=Yes) or not/never (=No)?	If Yes, how severe, intense or strong? □ mild □ moderate □ severe □ very severe
1. Had depressive mood (feeling down, sad, on the verge of tears, mood swings)		No □ Yes	□ □ □ □
2. Felt worried (anxious, feeling panicky)		No □ Yes	□ □ □ □
3. Felt restless or irritable (nervousness, feeling fidgety, inner tension, easily upset about little things)		No □ Yes	□ □ □ □
4. Experienced increase in appetite, sometimes food craving		No □ Yes	□ □ □ □
5. Felt that my weight increased		No □ Yes	□ □ □ □
6. Observed swelling of extremities (arms, legs)		No □ Yes	□ □ □ □
7. Experienced abdominal pain attacks (underbelly)		No □ Yes	□ □ □ □
8. Observed cramps of guts or bladder		No □ Yes	□ □ □ □
9. Had sometimes cyclic bleedings from guts or bladder observed		No □ Yes	□ □ □ □
10. Had strong menstrual bleeding	NB □	No □ Yes	□ □ □ □
11. Had painful menstrual period	NB □	No □ Yes	□ □ □ □
12. Had significant premenstrual complaints that improved when menstrual flow began	NB □	No □ Yes	□ □ □ □
13. Had less sexual fantasies or thoughts		No □ Yes	□ □ □ □
14. Had less satisfaction or enjoyment with sexual act		No □ Yes	□ □ □ □
15. Observed reduced sexual arousal		No □ Yes	□ □ □ □

Thank you for your kind cooperation