Saint Louis University
Center for Endometriosis Questionnaire
PRE-OPERATIVE

Patient Name: ________________________________ **Date:** ____________________

Date of Birth: ______/______/________ **Email:**____________________

A: DEMOGRAPHICS

A.1 State/Province where you reside: ________ **A.2 Age**: ____ **A.3 Height**: _____ **A.4 Weight**______

A.5 Ethnicity (check 1 of 2):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

A.6 Race:

☐ American Indian or Alaskan native
☐ Asian/Pacific/Oriental
☐ Black → ☐ Black African ☐ African American ☐ Black Caribbean
☐ Native Hawaiian or other Pacific Islanders
☐ White → ☐ North/West European ☐ East European ☐ South European
☐ North American ☐ Other: _________________ *(please specify)*
☐ Mixed Race
☐ Other: ______________________________________ *(please specify)*

A.7 What is your major ancestry (please check one)?

☐ Scandinavian ☐ African
☐ Irish / Celtic / British ☐ Asian
☐ Other Northern European ☐ Southern European / Mediterranean
☐ Eastern European ☐ Other (Please specify): ___________________________
☐ South American ☐ Don't know
☐ Central American or Caribbean

A.8 What is your natural hair color?

☐ Red ☐ Dark brown
☐ Blonde ☐ Black
☐ Light brown

A.9 What is your eye color?

☐ Blue ☐ Hazel
☐ Gray ☐ Brown
☐ Green

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A.10 Education: Currently in school (Yes/No)? ____

What is the highest level of education you have attained (with certificate)?

☐ Primary/grade school
☐ Lower secondary/middle school
☐ Upper secondary/high school
☐ Post-secondary not university/ some college or vocational school
☐ University
☐ Post-graduate

A.11 What is your *primary* reason for seeking consultation for surgery for suspected or known endometriosis?

☐ PAIN ☐ FERTILITY

B: MENSTRUAL HISTORY

B.1 At what age did you begin to have periods?

☐ 8 years or younger	☐ 12	☐ 16
☐ 9	☐ 13	☐ 17 years or older
☐ 10	☐ 14	☐ uncertain
☐ 11	☐ 15	☐ periods have not yet started

If you have not yet begun having periods please skip to section <u>D – General Pelvic/Abdominal Pain</u>

B.2 Have you had any periods in the last 3 months? (*We mean bleeding for which you needed a tampon or sanitary pad, NOT discharge (spotting) for which you needed a panty liner only*) ☐YES ☐NO

If you have NOT had periods in the last 3 months:

B.2.1 What was the reason for not having periods?

☐ Taking hormones continuously (*e.g. the Pill, injections, Mirena, HRT*)
☐ Pregnant/breastfeeding
☐ Unsure
☐ Other (Please describe) ________________________________

B.2.2 Approximately how many periods have you had over the last 12 months? _______

B.2.3 When was your last period?

☐ 3-6 months ago ☐ 7-12 months ago ☐ Over 12 months ago

If you have had periods in the last 3 months, please answer the following questions about your recent periods.

B.2.4 Were your periods in the last 3 months natural or hormone-induced (*e.g. on the Pill, injections, Mirena, or HRT*)?

☐ Natural ☐Hormone-induced

B.2.5 When was the first day of your last menstrual period?

☐ ___/___/_______(DD/MM/YYYY) ☐ Uncertain

B.2.6 Were your periods in the last 3 months regular?

- ☐ extremely regular (period starts 1-2 days before or after it is expected)
- ☐ very regular (period starts 3-4 days before or after it is expected)
- ☐ regular (period starts 5-7 days before or after it is expected)
- ☐ somewhat irregular (period starts 8-20 days before or after it is expected)
- ☐ irregular (period starts 20 days before or after it is expected)

B.2.7 How many days of bleeding did you usually have each period in the last 3 months? (Not counting discharge/spotting for which you need a panty liner only)

____ days OR ☐ Too irregular to say

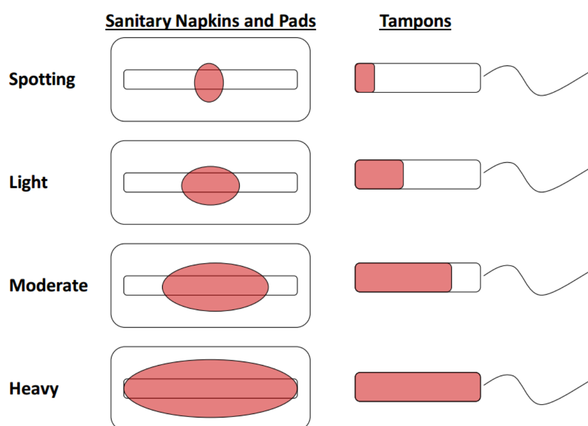
B.2.8 The figure below shows examples of the amount of bleeding you can experience **every four hours** during your period. Please describe the amount of bleeding you typically experience four-hourly during your period **at its heaviest,** and **on average.**

At its heaviest?

- ☐ Spotting
- ☐ Light
- ☐ Moderate
- ☐ Heavy

On average?

- ☐ Spotting
- ☐ Light
- ☐ Moderate
- ☐ Heavy



B.2.9 In the last 3 months, how many days were there between the first day of one period and first day of the next **on average**? (*Not including spotting*)

- ☐ <24 days
- ☐ 24-31 days
- ☐ 32-38 days
- ☐ 39-50 days
- ☐ 51+ days
- ☐ Too irregular to estimate

C. Pain With Your Period

The following questions ask about pelvic pain WITH your periods (*including irregular bleeding or bleeding while on hormonal treatments, but not spotting*). By pelvic pain, we mean any type of pain (cramping, shooting, stabbing, etc.) in the lower part of your belly.

C.1 Has there been a time in your life when you typically had pelvic pain during your periods?

☐ No pain → **Skip to question D.1**
☐ Mild cramps (medication never or rarely needed)
☐ Moderate cramps (medications usually needed)
☐ Severe cramps (medication and bed rest needed)

C.2 At what age did you start having period pain? _________ years old

If you have had a period in the last 3 months, please complete the following questions; otherwise, check here______ and please skip to question C.12

C.3 How much pelvic pain did you have **during your last period?**

☐ No pain → **Skip to question C.10**
☐ Mild cramps (medication never or rarely needed)
☐ Moderate cramps (medications usually needed)
☐ Severe cramps (medication and bed rest needed)

C.4 Did you take any pain-killers for pelvic pain **during your last period?**

☐ No
☐ Yes, pain-killers that were prescribed by a doctor
☐ Yes, pain-killers bought over-the-counter without prescription (e.g. aspirin, ibuprofen/Advil/Motrin, Tylenol/acetaminophen, naproxen/Aleve).

C.5 Did you take hormones to help alleviate pelvic pain **during your last period**, and if so, did it help to alleviate your pain?

☐ No
☐ Yes, but pain was not alleviated
☐ Yes, pain was at least somewhat alleviated

C.6 **During your last period**, did your pelvic pain prevent you from going to work or school or carrying out your daily activities (even if taking pain-killers)?

☐ Yes ☐ No

C.7 **During your last period**, did you have to lie down for any part of the day or longer because of your pelvic pain?

☐ Yes ☐ No

C.8 Please rate how severe your pelvic pain was at its worst **during your last period** using a scale from 0 to 10 where 0= no pain and 10=worst imaginable pain

No pain										Worst imaginable pain
0	1	2	3	4	5	6	7	8	9	10

C.9 The following questions are about your bowel movements/stool **when you had pelvic pain during your period in the last 3 months.**

When you had pelvic pain with your period in the last 3 months, how often…	**Never/ Rarely**	**Some-times**	**Often**	**Most of the time**	**Always**
(a) …did this pain get better or stop after you had a bowel movement?	☐	☐	☐	☐	☐
(b) …did this pain get worse after you had a bowel movement	☐	☐	☐	☐	☐
(c) …did you have more frequent bowel movements when the pain started?	☐	☐	☐	☐	☐
(d) …did you have less frequent bowel movements when the pain started?	☐	☐	☐	☐	☐
(e) …were your stools looser when the pain started?	☐	☐	☐	☐	☐
(f) …were your stools harder when the pain started?	☐	☐	☐	☐	☐

C.10 **In the last 12 months,** how often have you had pelvic pain during your period?

☐ Never
☐ Occasionally (less than a quarter of my periods)
☐ Often (a quarter to half of my periods)
☐ Usually (more than half of my periods)
☐ Always (every period)

C.11 Please rate how severe your pelvic pain was at its worst **during the last 12 months** using a scale from 0 to 10 where 0=no pain and 10=worst imaginable pain.

No pain										Worst imaginable pain
0	1	2	3	4	5	6	7	8	9	10

The following questions are about the time in your life when your pelvic pain during your periods was <u>at its worst</u>:

C.12 How old were you when your pelvic pain during your period was **at its worst**? ______ years

C.13 Please rate how severe your pelvic pain during your period was **at its worst** using a scale from 0 to 10 where 0= no pain and 10=worst imaginable pain.

No pain										**Worst imaginable pain**
0	1	2	3	4	5	6	7	8	9	10

C.14 During the time in your life when your pelvic pain during your period was **at its worst,** were you taking any medication to help alleviate the pain? (Check all that apply)

☐ No
☐ Yes, pain-killers that were prescribed by a doctor
☐ Yes, pain-killers bought over-the-counter without prescription (e.g. aspirin, ibuprofen/Advil/Motrin, Tylenol/acetaminophen, naproxen/Aleve).
☐ Yes, hormones, but pain was not alleviated
☐ Yes, hormones, pain was at least somewhat alleviated

C.15 Have you **ever** been on hormonal suppression (examples include birth control pills, injections, Mirena IUD) for **pain with menstrual cramps**? ☐YES ☐NO

If yes, at what age did you start using hormonal suppression for pain? ________

If yes**,** what have you tried **in the past**?

a. Cyclic (monthly bleed) Birth Control Pill ☐YES ☐NO
- *If YES how many MONTHS total lifetime* ___________
- *If YES what are the reasons?* ☐Pain ☐Other ☐Both

b. Continuous (bleed no more than every 3 months) Birth Control Pill ☐YES ☐NO
- *If YES how many MONTHS total lifetime* ___________
- *If YES what are the reasons?* ☐Pain ☐Other ☐Both

c. Mirena IUD ☐YES ☐NO
- *If YES how many MONTHS total lifetime* ___________
- *If YES what are the reasons?* ☐Pain ☐Other ☐Both

d. Depo Provera ☐YES ☐NO
- *If YES how many MONTHS total lifetime* ___________
- *If YES what are the reasons?* ☐Pain ☐Other ☐Both

e. Lupron ☐YES ☐NO
- *If YES how many MONTHS total lifetime* ___________
- *If YES what are the reasons?* ☐Pain ☐Other ☐Both

Are you **currently** on any of the medications listed above? If so which one? ________________

If NOT currently on hormonal suppression, when were you last on it (in months)?
______________/Never

D. General Pelvic/Abdominal Pain

The following questions ask about pelvic/lower abdominal pain in general. *Please DO NOT COUNT pain related to periods or intercourse, pregnancy or childbirth, any surgery, sports-related or other injury, food poisoning, or stomach flu.*

D.1 Have you ever experienced pelvic pain in general? DO NOT COUNT: pain caused by menstrual cramps, intercourse, surgery, pregnancy, childbirth, sports-related or other injury, food poisoning or stomach flu

☐ No → **Skip to question D.13**
☐ Yes → At what age did you start having this pelvic pain? _____years

→ When did you last have this pain?
☐ In the last month
☐ 1-3 months ago
☐ 4-6 months ago → **Skip to D.10**
☐ 7-12 months ago →**Skip to D.10**
☐ longer than 12 months ago →**Skip to D.10**

D.2 To what extent has your pelvic pain interfered with your normal social activities with each of the following activities **in the last 3 months**:

Work or school:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Quite a bit	☐ Extremely	☐ Not applicable
Daily activities at home:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Quite a bit	☐ Extremely	
Sleep:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Quite a bit	☐ Extremely	
Sexual intercourse:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Quite a bit	☐ Extremely	☐ Not applicable
Exercise/sports:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Quite a bit	☐ Extremely	☐ Not applicable
Social activities:	☐ Not at all	☐ Slightly	☐ Moderately	☐ Quite a bit	☐ Extremely	☐ Not applicable

D.3 Approximately how long in total did you have this pain **in the last 3 months**?

☐ Less than one day a month
☐ One day a month
☐ Two to three days a month
☐ One day a week
☐ More than one day a week
☐ Every day

D.4 Have you taken any medications to help alleviate the pain **in the last 3 months**? (Check all that apply)

☐ No
☐ Yes, pain-killers that were prescribed by a doctor
☐ Yes, pain-killers bought over-the-counter without prescription (e.g. aspirin, ibuprofen/Motrin/Advil, Tylenol/acetaminophen, naproxen/Aleve).
☐ Yes, hormones, but pain was not alleviated
☐ Yes, hormones, pain was at least somewhat alleviated

D.5 Please rate how severe your pelvic pain was at its worst **in the last 3 months** using a scale from 0 to 10 where 0=no pain and 10=worst imaginable pain.

No pain										Worst imaginable pain
0	1	2	3	4	5	6	7	8	9	10

D.6 When you had pelvic pain **in the last 3 months**, what did it feel like?

Throbbing	☐ None	☐ Mild	☐ Moderate	☐ Severe
Shooting	☐ None	☐ Mild	☐ Moderate	☐ Severe
Stabbing	☐ None	☐ Mild	☐ Moderate	☐ Severe
Sharp	☐ None	☐ Mild	☐ Moderate	☐ Severe
Cramping	☐ None	☐ Mild	☐ Moderate	☐ Severe
Gnawing	☐ None	☐ Mild	☐ Moderate	☐ Severe
Hot-Burning	☐ None	☐ Mild	☐ Moderate	☐ Severe
Aching	☐ None	☐ Mild	☐ Moderate	☐ Severe
Heavy	☐ None	☐ Mild	☐ Moderate	☐ Severe
Tender	☐ None	☐ Mild	☐ Moderate	☐ Severe
Splitting	☐ None	☐ Mild	☐ Moderate	☐ Severe
Tiring-Exhausting	☐ None	☐ Mild	☐ Moderate	☐ Severe
Sickening	☐ None	☐ Mild	☐ Moderate	☐ Severe
Fearful	☐ None	☐ Mild	☐ Moderate	☐ Severe
Punishing-Cruel	☐ None	☐ Mild	☐ Moderate	☐ Severe

D.7 What makes your pelvic pain worse? Please check all that apply.

☐ Sitting
☐ Full bladder or urinating
☐ Bowel movement
☐ Constipation
☐ Intercourse or orgasm
☐ Standing or walking
☐ Exercise
☐ Stress
☐ Time of day
☐ Full meal
☐ Weather
☐ Contact with clothing
☐ Coughing/sneezing
☐ Nothing makes my pain worse
☐ Other, please specify: ________________________________

D.8 What helps your pelvic pain? Please check all that apply.

☐ Pain medication
☐ Relaxation
☐ Lying down
☐ Music
☐ Massage
☐ Ice
☐ Heating pad
☐ Bowel movement
☐ Hot bath
☐ Meditation
☐ Laxatives / enema
☐ TENS Unit
☐ Emptying bladder
☐ Nothing helps
☐ Other, please specify: ________________________________

D.9 The following questions are about your bowel movements/stool when you had pelvic pain **in the last 3 months**:

When you had pelvic pain in the last 3 months, how often…	**Never/ Rarely**	**Some-times**	**Often**	**Most of the time**	**Always**
(a) …did this pain get better or stop after you had a bowel movement?	☐	☐	☐	☐	☐
(b) …did this pain get worse after you had a bowel movement	☐	☐	☐	☐	☐
(c) …did you have more frequent bowel movements when the pain started?	☐	☐	☐	☐	☐
(d) …did you have less frequent bowel movements when the pain started?	☐	☐	☐	☐	☐
(e) …were your stools looser when the pain started?	☐	☐	☐	☐	☐
(f) …were your stools harder when the pain started?	☐	☐	☐	☐	☐

The following questions are about the time in your life when your pelvic/lower abdominal pain was at its worst. *Please do not count: pain related to periods or intercourse, pregnancy or childbirth, any surgery, sports-related or other injury, food poisoning or stomach flu.*

D.10 How old were you when your pelvic/lower abdominal pain was **at its worst?** ____ years old

D.11 Please rate how severe your pelvic/lower abdominal pain was when it was **at its worst** using a scale from 0 to 10 where 0=no pain and 10=worst imaginable pain.

No pain										Worst imaginable pain
0	1	2	3	4	5	6	7	8	9	10

D.12 During the time in your life when your pelvic/lower abdominal pain was **at its worst** were you taking any medication to help alleviate the pain? (Please check all that apply)

☐ No
☐ Yes, pain-killers that were prescribed by a doctor
☐ Yes, pain-killers bought over-the-counter without prescription (e.g. aspirin, ibuprofen/Advil/Motrin, Tylenol/acetaminophen, naproxen).
☐ Yes, hormones, but pain was not alleviated
☐ Yes, hormones, pain was at least somewhat alleviated

D.13 Please indicate whether you have (had) the following other types of pain **in the last 12 months:**

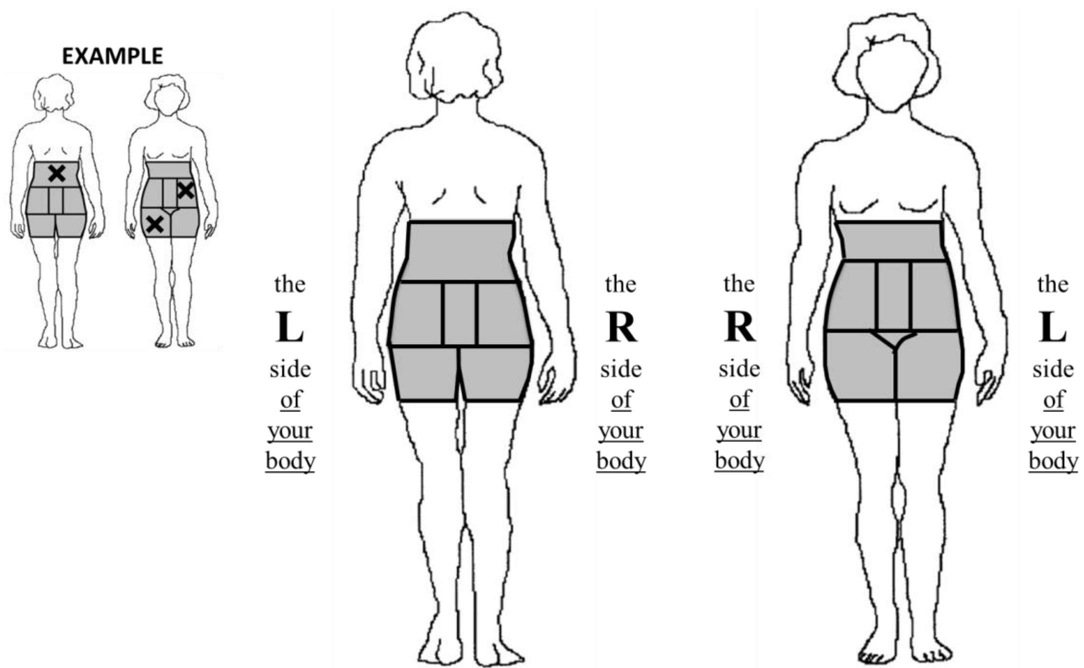
Low back pain	☐ No	☐ Yes, in last month	☐ Yes, more than 1 month ago
Muscle/joint pain unrelated to a viral infection or (sports) injury	☐ No	☐ Yes, in last month	☐ Yes, more than 1 month ago
Pain at ovulation (mid cycle)	☐ No	☐ Yes, in last month	☐ Yes, more than 1 month ago
Pain in legs	☐ No	☐ Yes, in last month	☐ Yes, more than 1 month ago
Pain with urination	☐ No	☐ Yes, in last month	☐ Yes, more than 1 month ago
Pain with bowel movement	☐ No	☐ Yes, in last month	☐ Yes, more than 1 month ago

SYMPTOMS

D.14 Please indicate if you CURRENTLY have the following symptoms AND rate their intensity on a scale from 0 to 10 (with 0 – none, 10 – worst imaginable)		**IF YES:** **Circle one** **(1 – 10, with 1 being least pain and 10 worst imaginable)**
Have you had chronic pelvic pain (meaning pelvic pain between the thighs and umbilicus not during the period) for at least 6 months?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have painful periods that affect your daily life?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have crampy, "period-like" pain, but without bleeding?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have low back pain that gets worse with your period?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10

Do you have pain with bowel movements or other bowel symptoms related to your period?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pain with urination, urinary frequency, or urgency?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have any deep pain with intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have superficial pain (on insertion) with intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pelvic pain that lingers for several hours after intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10

D.15 Noting the right and left side labels carefully, please put an 'X' on ALL areas where you experience pain regularly:



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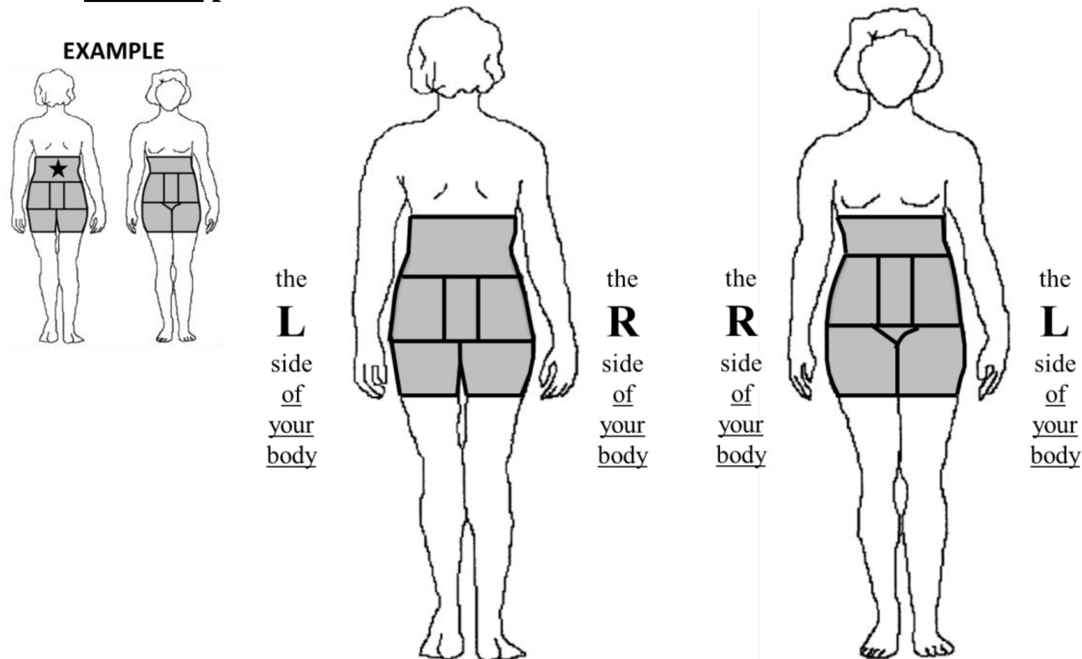
<u>D.16 Noting the right and left side labels carefully</u>, please put a star on <u>the ONE area</u> where you experience the <u>WORST</u> pain.



(Diagrams adapted from The International Pelvic Pain Society Assessment Form © April 2008 and Hsu *et al.* 2011)

D.17 We are interested in the types of thoughts and feelings that you have w**hen you are in pain.** Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	☐	☐	☐	☐	☐
I feel I can't go on	☐	☐	☐	☐	☐
It's terrible and I think it's never going to get any better	☐	☐	☐	☐	☐
It's awful and I feel that it overwhelms me	☐	☐	☐	☐	☐
I feel I can't stand it anymore	☐	☐	☐	☐	☐
I become afraid that the pain will get worse	☐	☐	☐	☐	☐
I keep thinking of other painful events	☐	☐	☐	☐	☐
I anxiously want the pain to go away	☐	☐	☐	☐	☐
I can't seem to keep it out of my mind	☐	☐	☐	☐	☐
I keep thinking about how much it hurts	☐	☐	☐	☐	☐
I keep thinking about how badly I want the pain to stop	☐	☐	☐	☐	☐
There's nothing I can do to reduce the intensity of the pain	☐	☐	☐	☐	☐
I wonder whether something serious may happen	☐	☐	☐	☐	☐

D.18 Please rate your **overall quality of life** (0 – worst imaginable, 100 - perfect):_____________

D.19 During the last 4 weeks, how often, because of your endometriosis, have you…

	Never	Rarely	Sometimes	Often	Always
Found it difficult to walk because of the pain?	☐	☐	☐	☐	☐
Felt as though your symptoms are ruling your life?	☐	☐	☐	☐	☐
Had mood swings?	☐	☐	☐	☐	☐
Felt others do not understand what you are going through?	☐	☐	☐	☐	☐
Felt your appearance has been affected?	☐	☐	☐	☐	☐

E. PAST TREATMENTS FOR PAIN:

E.1 Have you ever been to the Emergency Room for pelvic pain?

☐ No

☐ Yes → If yes, have you been given a specific diagnosis?

Yes

No

E.2 Have you ever received any diagnosis for pelvic pain from a doctor?

☐ No

☐ Yes: (tick all that apply):

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory bowel disease (e.g. Crohn's or Ulcerative Colitis)
- ☐ Endometriosis
- ☐ Fibroid(s)
- ☐ Ovarian cyst
- ☐ Pelvic inflammatory disease/infection
- ☐ Painful bladder/interstitial cystitis (NOT a bacterial bladder infection)
- ☐ Stress
- ☐ Other: ……………………………………………………………… (please describe)

E.3 Has a doctor or other health care provider ever diagnosed you with endometriosis?

☐ No **If no, skip to E.4**

☐ Yes → If yes, how was the diagnosis made? (check all that apply)

- ☐ laparoscopy of other surgical procedure
- ☐ ultrasound/MRI scan
- ☐ based on symptoms
- ☐ other, please describe: ___________________________________

→ What symptoms, if any, prompted you to see a health care provider before your diagnosis with endometriosis? (mark all that apply)

☐ Pain
☐ Infertility
☐ No symptoms
☐ Other (please specify): ______________________________

→ How old were you when you were first diagnosed with endometriosis? _____years old

→ Have you had surgery for endometriosis?
☐ No
☐ Yes

If yes, please answer the following two questions as best you can:

a) What was the most severe stage of endometriosis found? *(please circle one)*

None I II III IV not known

b) What type of treatment did you receive? *(please circle all that apply)*

None ablation excision post-op medication not known

E.4 Have you had previous surgery or diagnostic laparoscopy for pelvic pain or for infertility?
☐YES ☐NO

If yes, how many surgeries have you had? _____________

If yes, please list as best as possible the month and year of each surgery: _______________________

F. PAIN WITH INTERCOURSE

The following questions are about pelvic pain during or after vaginal intercourse or penetration.

If you have never had intercourse, please check here____ and skip to section I – Review of Symptoms

F.1 Are you, or have you ever been, sexually active? ☐ Yes ☐ No

F.2 Have you ever had pelvic pain during intercourse or in the 24 hours following vaginal sexual intercourse/penetration?
☐ No → **Please skip to section G – Pregnancy and Fertility**
☐ Yes. At what age did this pain start?

F.3 When did you last have vaginal intercourse?

☐ In the last month
☐ 1-3 months ago
☐ 4-12 months ago
☐ More than 12 months ago → If so, did you avoid intercourse because of pelvic pain? ☐ Yes ☐ No

→If you had vaginal intercourse more than 12 months ago, skip to question F.12

F.4 **When you last had vaginal intercourse/penetration**, did you have pelvic pain during or in the 24 hours following sexual intercourse?

☐ No → **Please skip to question F.12**
☐ Yes, during intercourse/penetration
☐ Yes, in the 24 hours following intercourse/penetration
☐ Yes, both during intercourse/penetration and in the 24 hours following

F.5 **When you last had vaginal intercourse/penetration**, where did you feel the pain? *Check all that apply.*

☐ At the entrance of the vagina
☐ Deep inside the vagina
☐ Inside the abdomen/pelvis
☐ Other location (please describe): ____

F.6 Please rate how severe your pelvic pain was **during** the last time you had vaginal intercourse/penetration using a scale from 0 to 10 where 0=no pain and 10=worst pain imaginable.

No pain										Worst imaginable pain
0	1	2	3	4	5	6	7	8	9	10

F.7 Please rate how severe your pelvic pain was **in the 24 hours after** the last time you had vaginal intercourse/penetration using a scale from 0 to 10 where 0=no pain and 10=worst pain imaginable.

No pain										Worst imaginable pain
0	1	2	3	4	5	6	7	8	9	10

F.8 During times you had vaginal intercourse/penetration **in the last 12 months**, how often did you have pelvic pain during or in the 24 hours after intercourse?

☐ Occasionally (less than a quarter of times)
☐ Often (a quarter to half of the times)
☐ Usually (more than half of the times)
☐ Always (every time)

F.9 **In the last 12 months**, was there a time of the month in which vaginal intercourse/penetration was more painful than at other times? (mark all that apply)

	Was intercourse/vaginal penetration attempted during this time frame?		If yes, was it more painful at this time than other times?
During a period?	☐ No ☐ Yes	→	☐ No ☐ Yes
A few days before a period	☐ No ☐ Yes	→	☐ No ☐ Yes
A few days after a period	☐ No ☐ Yes	→	☐ No ☐ Yes
At mid cycle (around ovulation)	☐ No ☐ Yes	→	☐ No ☐ Yes

F.10 **In the last 12 months**, did you ever **interrupt** vaginal intercourse/penetration because of pelvic pain?

☐ Yes ☐ No

F.11 **In the last 12 months**, did you ever **avoid** vaginal intercourse/penetration because of pelvic pain?

☐ Yes ☐ No

The following questions are about the time in your life when your pain with vaginal intercourse/penetration was <u>at its worst</u>.

F.12 How old were you when your pelvic pain with vaginal intercourse/penetration was **at its worst**?

____ years old

F.13 Please rate how severe your pelvic pain with vaginal intercourse/penetration was when it was **at its worst** using a scale from 0 to 10 where 0=no pain and 10=worst imaginable pain.

No pain										**Worst imaginable pain**
0	1	2	3	4	5	6	7	8	9	10

G. PREGNANCY AND FERTILITY:

G.1 Have you ever been pregnant (confirmed by a positive pregnancy test, including miscarriages, ectopic pregnancies or terminations)? ☐YES, please complete the table below ☐NO

G.2 Please fill out the following table regarding your pregnancy history:

Pregnancy Number

	1	2	3	4	5	6	7	8
General								
Please write your age at the start of each pregnancy								
Month and year of conception (mm/yy)								
Date pregnancy ended (mm/dd/yy)								
How far along were you (in weeks) when this pregnancy ended?								
Was your pregnancy with your current partner? (Y/N)								
What fertility treatment was used, if any for this pregnancy? (Please tick ✓answers)								
Natural conception; no fertility treatment								
Fertility drugs by pills to stimulate ovulation (clomid, clomiphene)								
Intrauterine insemination (IUI)								
In vitro fertilization (IVF/ICSI)								
Did you have medical assistance to help conceive or maintain pregnancy?								
(Please write Y or N)								
How long did it take to achieve this pregnancy?								
Total years and months (yy, mm)								
Not applicable								
Pregnancy Outcome (Please tick ✓all that apply)								
Single live birth								
Twins or triplets								
Miscarriage								
Stillbirth								
Termination (abortion)								
Tubal or pregnancy in location outside uterus								
Molar								
Currently pregnant								
If this pregnancy was a miscarriage, tubal/ectopic, or if you had a termination, how was this managed?								
Surgically (D&C)								
Medically (with tablets either orally and/or vaginally)								
No management was needed								
Pregnancies Resulting in a Birth								
Indicate delivery method (V= Vaginal, C= C-section)								
Sex of baby(ies) (indicate M/F)								
Birth weight of baby (ies) (lbs/oz)								
Did you go into labor, and if so, was it induced? (Please tick ✓answers)								
Did not go into labor								
Spontaneous labor								
Induced labor								
Did you or the baby have the following complications related to pregnancy or breast feeding? (Check ✓all that apply)								
Gestational diabetes								
Pregnancy-related high blood pressure								
Pre-eclampsia/toxemia of pregnancy								
Mastitis/breast infection								
HELLP syndrome								
Hyperemesis gravidarum								
Pre-term birth (birth before 37 weeks)								
*Other (If yes, please comment below)								
If the pregnancy resulted in a birth, for how long did you breastfeed?								
(Please write the number of months you breastfed or write ‘0’ if you did not breastfeed; if you breastfed for less than 1 month, please write ‘1’)								

Please comment on any additional pregnancy or birth complications (indicate which pregnancy #):
____
____
____

G.3 Have you gone more than 12 months of being sexually active without any form of contraception or consistent avoiding behavior (including birth control pills or other hormonal contracption, barriers, or "pull out" or withdrawal), but without getting pregnant? ☐YES ☐NO

If yes, what you the longest amount of time you have gone like this (in months)?___________

G.4 Have you tried to get pregnant (which would include fertility-focused intercourse FFI) for more than 6 months in a row without succeeding? ☐YES ☐NO

If yes, what is the longest time, whether or not you actually got pregnant (in months)?

____

If no, skip to section H – Female Sexual Function Index

G.6 Have you or your partner ever had any tests/investigations to find out why you were not getting pregnant?

☐YES ☐NO

If yes: What were the results of these tests? (*Please check all that apply*).

☐ Endometriosis
☐ Adhesions
☐ Blocked tubes
☐ Polycystic ovary syndrome (PCOS)
☐ Pelvic inflammatory disease
☐ No/irregular ovulation
☐ Poor sperm count/quality
☐ Uterine fibroids
☐ No cause was found
☐ I can't remember
☐ Other…………………………

G.7 Did you ever seek treatment for infertility in any clinic? ☐YES ☐NO

If yes, Please tell us about any fertility treatment you have used.

	Never used	**Used within the last three months**	**Used, but not within the last three months**	**Number of cycles (if applicable)**
Intercourse timed specifically to conceive				……..
Fertility drugs by pills to stimulate ovulation (clomid, clomiphene or any other drug in pill form)				……..
Fertility drugs by injection (gonadotropins, HCG, or any other drug by injection)				
Progesterone (vaginal or intramuscular injection)				……..
Insemination with your partner's semen				……..
Intrauterine insemination with a donor's semen				……..
Targeted luteal phase support				……..
Cervical mucus enhancers				……..
In vitro fertilization (IVF)				……..
In vitro fertilization with intracytoplasmic sperm injection (ICSI)				……..
In vitro fertilization with eggs from a donor				……..

If you have ever had IVF, ICSI, or IVF with donor egg(s): After what step did your IVF cycle(s) end? (mark all that apply)

☐ Ovarian stimulation (did not have eggs to retrieve)
☐ Egg retrieval (did not have embryos transferred)
☐ Embryo transfer (did not have a positive pregnancy test)
☐ Chemical pregnancy (had a positive pregnancy test but no heartbeat on ultrasound)
☐ Clinical pregnancy (heartbeat detected, but pregnancy lost before end of 12 weeks)
☐ Pregnancy loss or stillbirth after 12 weeks
☐ Live birth

H. Female Sexual Function Index (FSFI):

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse. Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

H.1 Over the past 4 weeks, how often did you feel sexual desire or interest?

☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

H.2 Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?

☐ Very high
☐ High
☐ Moderate
☐ Low
☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

H.3 Over the past 4 weeks, how often did you feel sexually aroused ("turned on") during sexual activity or intercourse?

☐ No sexual activity
☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

H.4 Over the past 4 weeks, how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?

☐ No sexual activity
☐ Very high
☐ High
☐ Moderate
☐ Low
☐ Very low or none at all

H.5 Over the past 4 weeks, how confident were you about becoming sexually aroused during sexual activity or intercourse?

☐ No sexual activity
☐ Very high confidence
☐ High confidence
☐ Moderate confidence
☐ Low confidence
☐ Very low or no confidence

H.6 Over the past 4 weeks, how often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

☐ No sexual activity
☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

H.7 Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?

☐ No sexual activity
☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

H.8 Over the past 4 weeks, how difficult was it to become lubricated ("wet") during sexual activity or intercourse?

☐ No sexual activity
☐ Extremely difficult or impossible
☐ Very difficult
☐ Difficult
☐ Slightly difficult
☐ Not difficult

H.9 Over the past 4 weeks, how often did you maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

☐ No sexual activity
☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

H.10 Over the past 4 weeks, how difficult was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

☐ No sexual activity
☐ Extremely difficult or impossible
☐ Very difficult
☐ Difficult
☐ Slightly difficult
☐ Not difficult

H.11 Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?

☐ No sexual activity
☐ Almost always or always
☐ Most times (more than half the time)
☐ Sometimes (about half the time)
☐ A few times (less than half the time)
☐ Almost never or never

H.12 Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?

☐ No sexual activity
☐ Extremely difficult or impossible
☐ Very difficult
☐ Difficult
☐ Slightly difficult
☐ Not difficult

H.13 Over the past 4 weeks, how satisfied were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

☐ No sexual activity
☐ Very satisfied
☐ Moderately satisfied
☐ About equally satisfied and dissatisfied
☐ Moderately dissatisfied
☐ Very dissatisfied

H.14 Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?

☐ No sexual activity
☐ Very satisfied
☐ Moderately satisfied
☐ About equally satisfied and dissatisfied
☐ Moderately dissatisfied
☐ Very dissatisfied

H.15 Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?

☐ Very satisfied
☐ Moderately satisfied
☐ About equally satisfied and dissatisfied
☐ Moderately dissatisfied
☐ Very dissatisfied

H.16 Over the past 4 weeks, how satisfied have you been with your overall sexual life?

☐ Very satisfied
☐ Moderately satisfied
☐ About equally satisfied and dissatisfied
☐ Moderately dissatisfied
☐ Very dissatisfied

H.17 Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

H.18 Over the past 4 weeks, how often did you experience discomfort or pain following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

H.19 Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

I. REVIEW OF SYMPTOMS: Please circle if you have had these or circle none.

Constitutional:	Fever, chills, sweats, fatigue, malaise, anorexia, weight loss	None
Eyes:	Contacts/ glasses, cataracts, glaucoma, visual disturbance, irritation, redness, yellow in eyes, color blindness.	None
Head and Neck:	Hearing loss, ringing in ears, ear drainage, earache, nasal congestion, bloody noses, snoring, sore mouth, sore throat, hoarseness, voice changes	None
Breathing:	Cough, sputum, coughing up blood, pleurisy, pneumonia, asthma, wheezing, shortness of breath on exertion, emphysema.	None
Heart and Circulation	Chest pain, chest discomfort, shortness of breath, palpitations, irregular heartbeat, near fainting, fainting, fatigue.	None
Intestinal:	Difficulty swallowing, painful swallowing, reflux/ heartburn, nausea, vomiting, change in bowel habits, black or bloody stool.	None
Genitourinary:	Frequent urination, painful urination, waking up to urinate at night, leaking urine, difficulty starting to urinate, decreased stream, blood in urine.	None
Skin and Breast:	Rash, skin lesions, itching, dryness, skin color change, change in mole, breast lump, nipple discharge.	None
Blood:	Easy bruising, bleeding easily, swollen glands, broken blood vessels.	None
Muscles	Pain in muscles, joint pain, still joints, neck pain, back pain, muscle weakness, bone pain.	None
Nerves	Headache, dizziness, seizures, memory problems, speech problems, tingling, coordination problems, difficulty walking, tremor, weakness.	None
Psychiatric	Abusive relationship, ADHD, aggressive behavior, anorexia, anxiety, bad moods, behavior problems, bipolar, borderline personality, depression, alcoholism.	None
Glands	Diabetes, fertility problems, temperature intolerance.	None
Allergy	Rashes, hay fever, angioedema, anaphylaxis.	None

J. MEDICAL HISTORY

J.1 When was your last pap smear? (Fill in a date or circle never). _____Month_____Year /Never

→*If you have had a pap smear*, have you ever had an abnormal pap smear? ☐YES ☐NO

➔ If you have had an abnormal pap smear, what kind of abnormalities was noted? (check all that apply)

☐ Inflammation ☐ Abnormal cells ☐ Dysplasia ☐ Cancer ☐ Papilloma (wart) virus

☐ Unsure

J.2 Have you ever had a sexually transmitted disease (STD)? ☐YES ☐NO

If yes, what did you have and when was it diagnosed? ______________

When were you last tested negative for an STD? (Month/year) ______________

J.3 When was your last mammogram? (Or never) ______________/Never

J.4 When was your last colonoscopy? (Or never) _____________/Never

J.5 Have you ever used emergency contraception?

☐ No
☐ Yes → If yes, have you used emergency contraception in the last 3 months? ☐YES ☐NO

J.6 Have you ever used hormones?
Yes, currently on
Yes, in the past
No, not ever – skip to question J.8

J.7 What are/were your reasons for using hormones? Check all that apply.

☐ I have not ever used hormones
☐ Birth control / pregnancy prevention
☐ Pelvic pain or pain with periods
If yes: Did hormones help with the pain? ☐ Yes ☐ No
If yes: Did you ever discontinue or change hormones because they were not effective at controlling pain? ☐ Yes ☐ No
☐ Irregular periods
☐ Heavy periods
☐ Acne
☐ Polycystic ovarian syndrome (PCOS)
☐ Ovarian cyst
☐ Other (please specify): ____

J.8 Have you ever used a non-hormonal coil/IUD?

☐ No – skip to question J.10
☐ Yes → If yes, at what age did you first use a non-hormonal coil/IUD? _____
Have you used a non-hormonal coil/IUD in the last 3 months? ☐YES ☐NO
How long have you used a non-hormonal coil/IUD? _____ months _____ years

J.9 Please list below all hormones you have **ever** used for any reason (acne, bad cramping, irregular periods, birth control, fertility treatments). For each hormone used, please indicate what type of hormone it was using the number indicated for the categories below. Please also tell us the age you first used each hormone and the total time used. If you cannot remember the name of the hormone you used, please write "unknown" in the first column.

1=Combined birth control pill (e.g. Marvelon, Yasmin, Microgynon)
2=Progestin only birth control pill ("mini-pill", e.g. Cerazette, Micronor)
3=Unsure of which type of oral birth control pill
4=Progestin injection/shot (e.g. Depo provera)
5=Transdermals: patches (e.g. OrthoEvra, Climara), dots (Vivelle dot)
6=Vaginal ring (NuvaRing)
7=Progesterone containing coil/IUD (Mirena)
8=Hormonal implant (Implanon/Nexplanon)
9=Oral progestins to regulate the cycle (e.g. medroxyprogesterone acetate [Provera], dydrogesterone [Duphaston], dienogest [Visanne], Norethisterone)
10=GnRH agonist injection/shot (e.g. leuprolilide (leuproline) acetate [Prostap], goserelin [Zoladex])
11=Norethindrone acetate (Aygestin)
12=Danazol (please specify if used vaginally or orally)
13=Hormone replacement therapy (e.g. Premarin, Provera)
14=Other
15=Don't know what type of hormone

Name of hormone	Type of hormone (Please enter the number associated with the category above.)	Age started	Used within the last 3 months?	Total time used	If the hormone used was an injection, please note the date of the last injection
For example: Yasmin	*1*	*18*	✔ *No* ☐ *Yes*	*...... months* *2 years*	......./......./...... *DD MM YY*
1.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
2.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
3.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
4.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
5.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
6.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
7.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
8.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
9.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY
10.	....	....	☐ No ☐ Yes	...... months ...... years	......./......./...... DD MM YY

J.10 Please tell us about any pain medications, over-the-counter or prescription, that you have used at least once a week for a period of **3 months or longer**:

PAIN RELIEF DRUG TABLE

Type of drug	Ever used? ✓ *if yes*	Currently taking? ✓ *if yes*	At what age did you first take this drug regularly?	For what pain was this medication used?	How many days per week?	How many tablets per week?	In total, how long have you used this drug?
Paracetamol/acetaminophen	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Aspirin (325 mg or more/tablet)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Ibuprofen (e.g., Brufen)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Celebrex, Vioxx (COX-2 inhibitors)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Other anti-inflammatory analgesics (naproxen, mefanamic acid, Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Strong (narcotic) analgesics (hydrocodone +paracetamol, codeine+paracetamol, morphine, codeine, oxycodone, hydrocodone, Demerol)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Other pain-killing drugs aimed at the nerves/central nervous system (amitriptyline, nortriptyline, gabapentin, pregabalin, lamotrigine)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Muscle relaxants (diazepam/temazepam, buscopan)	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years
Herbal medicines	☐	☐	____	☐ Pelvic pain ☐ Other pain ☐ Both	☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6+	☐ 1-2 ☐ 3-5 ☐ 6-14 ☐ 15+	____ months ____ years

J.11 Have you ever taken prescription drugs for more than 3 months, excluding hormone treatments and pain medications? ☐ No – skip to question J.12 ☐ If yes, please fill out the table below.

PRESCRIPTION DRUG TABLE

Type of drug	**Have you ever taken this drug every day for over a month?**	**At what age did you first take this drug every day for over a month?**	**In total, how many years you have taken this drug? Please estimate, and enter "0 total years" if less than 1 year.**	**Are you currently taking this drug every day?**	**Please write down the specific name of the drug you have used most recently if known:**
	✓ *if yes*	*Age 1st*	*Years taken:*	✓ *if yes*	*Name of drug:*
a. Diuretic (water pill)	☐	__ __	__ __	☐	
b. Diabetic tablets	☐	__ __	__ __	☐	
c. Insulin	☐	__ __	__ __	☐	
d. Thyroid drugs	☐	__ __	__ __	☐	
e. Drugs for epilepsy	☐	__ __	__ __	☐	
f. Sleeping tablets / tranquilisers	☐	__ __	__ __	☐	
g. Anti-depressants	☐	__ __	__ __	☐	
h. Other drugs to treat mental illness	☐	__ __	__ __	☐	
i. Drugs for osteoporosis ("brittle bones")	☐	__ __	__ __	☐	
j. Drugs for rheumatoid arthritis	☐	__ __	__ __	☐	
k. Antibiotics for a month or more	☐	__ __	__ __	☐	
l. Antacids	☐	__ __	__ __	☐	
m. Drugs for stomach ulcer / gastritis	☐	__ __	__ __	☐	
n. Drugs for high cholesterol	☐	__ __	__ __	☐	
o. Drugs for allergies (antihistamines)	☐	__ __	__ __	☐	
p. Steroids (oral, inhaled, or nasal)	☐	__ __	__ __	☐	
q. Chemotherapy for cancer	☐	__ __	__ __	☐	
r. Tamoxifen for cancer	☐	__ __	__ __	☐	
s. Blood pressure drugs	☐	__ __	__ __	☐	
t. Drugs for angina (chest pain)	☐	__ __	__ __	☐	
u. Other drugs for a heart condition	☐	__ __	__ __	☐	
v. Inhaler for asthma	☐	__ __	__ __	☐	
w. Warfarin / heparin to thin blood	☐	__ __	__ __	☐	
x. Migraine tablets/injections	☐	__ __	__ __	☐	
Other 1:	☐	__ __	__ __	☐	
Other 2:	☐	__ __	__ __	☐	
Other 3:	☐	__ __	__ __	☐	
Other 4:	☐	__ __	__ __	☐	
Other 5:	☐	__ __	__ __	☐	

J.12 MEDICAL PROBLEMS: Please Circle YES or NO

Abnormal Pap	Y	N	Anemia	Y	N	Anesthetic Complications	Y	N
Arthritis	Y	N	Asthma	Y	N	Bladder/ Kidney Infections	Y	N
Cancer	Y	N	Cataracts	Y	N	Chlamydia	Y	N
Crohn's Disease/ Ulcerative Colitis	Y	N	Congenital Heart Disease	Y	N	Congestive Heart Failure	Y	N
Depression	Y	N	DVT (blood clots)	Y	N	Emphysema/ COPD	Y	N
Epilepsy/ Seizures	Y	N	Fibromyalgia	Y	N	Gestational Diabetes	Y	N
Glaucoma	Y	N	Gonorrhea	Y	N	Heart Attack	Y	N
Heart Murmur	Y	N	Heart Problems	Y	N	Hepatitis: Viral	Y	N
Heartburn/ GERD	Y	N	Herpes	Y	N	HIV/ AIDS	Y	N
HPV	Y	N	Hypertension	Y	N	Irritable Bowel Syndrome	Y	N
Interstitial Cystitis	Y	N	Kidney Disease	Y	N	Kidney Stones	Y	N
Migraines	Y	N	Osteoporosis/ Penia	Y	N	Pulmonary Embolus	Y	N
Sickle Cell Trait	Y	N	Sickle Cell Disease	Y	N	Stroke	Y	N
Syphilis	Y	N	Thyroid Disease	Y	N	Trichomonas	Y	N
Tuberculosis	Y	N	Type 1 Diabetes	Y	N	Type 2 Diabetes	Y	N
Allergies such as hay fever	Y	N	Chronic fatigue syndrome	Y	N	Frequent constipation	Y	N
Frequent diarrhea	Y	N	Liver diseases	Y	N	Lupus erythematosus	Y	N
Multiple sclerosis	Y	N	Scleroderma	Y	N	Seizures	Y	N
Sjogren's syndrome	Y	N	Urinary Tract Infections	Y	N	Varicose veins	Y	N
Anxiety requiring medication or therapy	Y	N	Deafness/difficulty hearing	Y	N	Eczema	Y	N
Fibroid uterus	Y	N	Glandular fever	Y	N	Graves' Disease	Y	N
Hashimoto's disease	Y	N	Mitral valve prolapse	Y	N	Pelvic inflammatory disease (PID)	Y	N
Polycystic ovary syndrome (PCOS)	Y	N	Scoliosis	Y	N	Spine problems (excluding scoliosis)	Y	N
Ulcerative colitis	Y	N						

J.13 Other medical problems not mentioned above: ____

J.14 Have you ever been diagnosed by a doctor with cancer or a malignancy of any kind?

☐ No ☐ Yes

If yes, what type(s) of cancer (primary location) have you been diagnosed with, and when were you first diagnosed?

Type of Cancer	Age first diagnosed (years)

J.15 Have you been told that you were born with a structural problem/birth defect of your uterus, cervix, or vagina?

☐ No
☐ Yes → If yes, did you have surgery for this issue?
  ☐ No
  ☐ Yes → If yes, was the problem improved or corrected after surgery?
    ☐ No
    ☐ Yes

J.16 The following questions are about your bowel movements/stool in general **in the last 3 months**:

In the last 3 months, how often...	**Never/ Rarely**	**Some-times**	**Often**	**Most of the time**	**Always**
...did you have loose, mushy, or watery stools?	☐	☐	☐	☐	☐
...did you have hard or lumpy stools?	☐	☐	☐	☐	☐

J.17 Have you had any of the following **in the last 3 months?** *Check all that apply*.

☐ Rectal bleeding or blood in your stool
☐ Less than 3 bowel movements per week
☐ More than 3 bowel movements per day
☐ Nausea and/or vomiting
☐ Intestinal cramping
☐ Straining during a bowel movement
☐ Urgent need to have a bowel movement
☐ Feeling of incomplete emptying with bowel movements
☐ Passing mucus at the time of bowel movements
☐ Abdominal fullness, bloating, or swelling

J.18 **In the last 3 months,** have you experienced any of the following? *Check all that apply*.

☐ Loss of urine when coughing, sneezing or laughing
☐ Difficulty passing urine
☐ Frequent bladder infections
☐ Blood in the urine
☐ Still feeling full after urination
☐ Having to urinate again within minutes of urinating

K. SURGICAL HISTORY: Please Circle YES or NO

K.1 Have you had any of the following surgical procedures during your life? If so, at approximately what age(s) did you have the procedures(s), how many have you had in total, and what was the reason for the surgery?

Surgical Procedures	**No**	**Yes**	**If Yes:** How many times in total?	Please list age(s)	What was the reason for the surgery?
Tubal ligation (sterilization/tubes tied)	☐	☐		Age:….	
Appendix removed	☐	☐		Age:….	
Hysterectomy ☐ vaginal ☐ abdominal	☐	☐		Age:….	
Oophorectomy If yes, how many of your ovaries have been removed? ☐ 1 ☐ both ☐ unsure	☐	☐		Age(s):… ………..	…………………… ……………………
Dilation and Curettage (D&C)	☐	☐		Age(s):… ………..	…………………… ……………………

Cervical surgery (LEEP or conization)	☐	☐		Age(s):… ………..	…………………… ……………………
Cervical cerclage	☐	☐		Age(s):… ………..	…………………… ……………………
Cervical biopsy	☐	☐		Age(s):… ………..	…………………… ……………………
Vulvar biopsy	☐	☐		Age(s):… ………..	…………………… ……………………
Ovarian cyst removed	☐	☐		Age(s):… ………..	…………………… ……………………
Hysteroscopy	☐	☐		Age(s):… ………..	…………………… ……………………
Gall bladder surgery	☐	☐		Age(s):… ………..	…………………… ……………………
Hernia operation	☐	☐		Age(s):… ………..	…………………… ……………………
Sigmoidoscopy/colonoscopy (insertion of a tube to look inside your bowel)	☐	☐		Age(s):… ………..	…………………… ……………………
Laparoscopy (surgery involving insertion of a telescope into your abdomen)	☐	☐			
1st	☐	☐		Age:….	…………………… ……………………
2nd	☐	☐		Age:….	…………………… ……………………
3rd	☐	☐		Age:….	…………………… ……………………
4th	☐	☐		Age:….	…………………… ……………………
5th or last	☐	☐		Age:….	…………………… ……………………
Other abdominal surgery: …………………………………	☐	☐		Age(s):… ………..	…………………… ……………………
Mastectomy	☐	☐		Age(s):… ………..	…………………… ……………………
Tonsillectomy	☐	☐		Age:….	
Heart bypass surgery	☐	☐		Age(s):… ………..	…………………… ……………………

L. FAMILY HISTORY

L.1 Have any of your female blood relatives ever been diagnosed with endometriosis or suffered from chronic pelvic pain?

Condition	Mother	Sister	Grandmother, aunt or cousin on mother's side	Grandmother, aunt or cousin on father's side
Endometriosis	☐ No ☐ Yes ☐ Do not know	☐ No ☐ Yes ☐ Do not know ☐ Do not have a sister	☐ No ☐ Yes ☐ Do not know	☐ No ☐ Yes ☐ Do not know
Chronic pelvic pain	☐ No ☐ Yes ☐ Do not know	☐ No ☐ Yes ☐ Do not know ☐ Do not have a sister	☐ No ☐ Yes ☐ Do not know	☐ No ☐ Yes ☐ Do not know

L.2 Please fill in the chart below and check the appropriate boxes.

Relationship	Status (Alive/Deceased)	Diabetes	Breast Cancer	Ovarian Cancer	Colon Cancer	Osteoporosis	Heart Disease	Hypertension	Elevated Lipids	Deep Vein Thrombosis	Pulmonary Embolism	Depression	Endometriosis	Interstitial Cyst	Vulvudynia	Prostate Cancer	Uterine Cancer	Stroke
Paternal Grandfather																		
Paternal Grandmother																		
Maternal Grandfather																		
Maternal Grandmother																		
Father																		
Mother																		
Brother																		
Sister																		
Child																		
Other																		

M. SOCIAL HISTORY: Tell me about yourself and your habits.

TOBACCO USE

L.1 Do you currently smoke cigarettes?

☐ YES → If yes, please complete: I have smoked _______ packs per day for______ years
→ If yes, at what age did you start smoking? ______ years old

☐ NO → If no, do you use tobacco in another form (chewing tobacco, snuff, pipes, cigars)?
☐YES ☐NO

→ If no, have you ever smoked cigarettes?
☐YES , but I stopped smoking at age _____
☐ NO –skip to L.3

L.2 Have you smoked more than 100 cigarettes in your lifetime? ☐YES ☐NO

ALCOHOL USE

L.3 Do you drink any alcohol?

☐ YES → If yes, how many total drinks do you consume per week? __________
→ If yes, during an average week, how much do you drink of the following (Please note exact numbers, not ranges such as 1-3):

Type of alcohol (serving size)	Average number of each drink per week
Beer/lager/cider (half pints (284 ml)	………
Sherry/vermouth/port (50 ml)	………
Wine (175 ml)	………
Spirits (25 ml)	………
Other (*Please specify*) ………………………	………

☐ NO

STREET DRUG USE

L.4 Do you use any street drugs?

☐ YES → If yes, list kinds: ______________________________________

☐ NO

RELATIONSHIPS

L.5 Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

L.6 Sexual preferences:

☐ Men ☐ Women ☐ Both

L.7 Do you have a history of abuse? ☐YES ☐NO

EXERCISE

L.8 During the last 12 months, what was your average time per week spent on each of the following recreational activities?

	Zero	1-4 min	5-19 min	20-59 min	One hour	1-1.5 hours	2-3 hours	4-6 hours	7-10 hours	11+ hours
Walking or hiking outdoors (include walking to work)										
Jogging (slower than 10 minutes/mile)										
Running (10 minutes/mile or faster)										
Bicycling (include stationary machine)										
Calisthenics/aerobics/aerobic dance/rowing machine										
Tennis, squash, racquetball										
Lap swimming										
Other aerobic recreation (e.g., lawn mowing)										