WERF EPHect Questionnaire – Minimum (EPQ-M)

(March 2014)

Menstrual history and hormones

A1. How old were you when you had your first menstrual period?

☐ 8 years or younger
☐ 9
☐ 10
☐ 11
☐ 12
☐ 13
☐ 14
☐ 15
☐ 16
☐ 17 years or older
☐ uncertain
☐ periods have not started yet, **please skip to question C1**

A2. 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)*

☐ No
☐ Yes

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

A2.1. What was the reason for not having periods?

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

A2.2. Approximately how many periods have you had over the last 12 months? _____

A2.3. 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.

A2.4. Were your periods in the last 3 months natural or hormone-induced (*e.g. on the Pill, injections, Mirena or HRT*)?

☐ Natural ☐ Hormone induced

A2.5. When was the first day of your last menstrual period (LMP)?

LMP___/___/_____ ☐ Uncertain
DD MM YYYY

A2.6. 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 more than 20 days before or after it is expected)

A2.7. 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

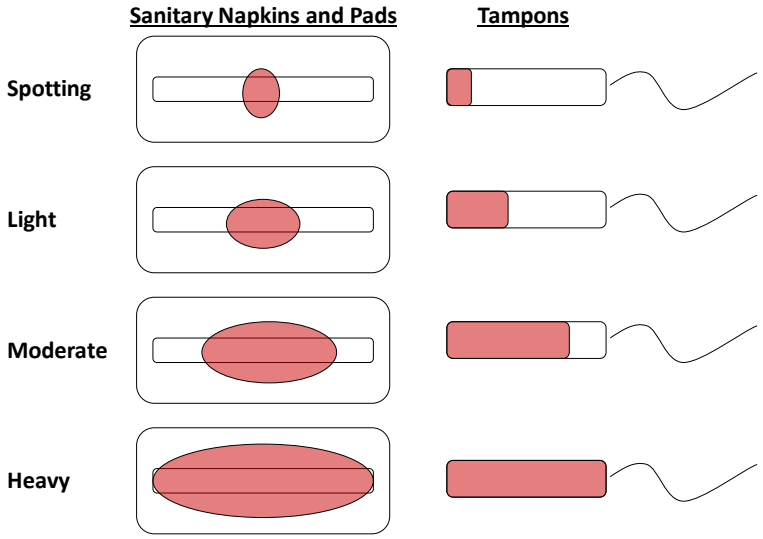
A2.8. The figure below shows examples of the amount of bleeding you can experience **every four hours** during your period. Please describe the amount of bleeding you typically experience four-hourly during your period **at its heaviest**, and **on average**.

At its heaviest?

☐ Spotting
☐ Light
☐ Moderate
☐ Heavy

On average?

☐ Spotting
☐ Light
☐ Moderate
☐ Heavy



A2.9. In the last 3 months, how many days were there between the first day of one period and the 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

A3. 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

A4. Have you ever used emergency contraception?

☐ No

☐ Yes → If yes: A5.1. Have you used emergency contraception in the last 3 months?

☐ No

☐ Yes

A5. What are/were your reasons for using hormones?

(Check all that apply).

☐ Birth control / pregnancy prevention

☐ Pelvic pain or pain with periods

If yes: A6.1. Did hormones help with the pain? ☐ Yes ☐ No

A6.2. Did you ever discontinue or change hormones because they were not effective enough at controlling pain? ☐ Yes ☐ No

☐ Irregular periods

☐ Heavy periods

☐ Acne

☐ Polycystic ovarian syndrome (PCOS)

☐ Ovarian cyst

☐ Other (please specify): _____

A6. Have you ever used a non-hormonal coil/IUD?

☐ No

☐ 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

Pregnancy and fertility

B1. Have you ever been pregnant (confirmed by a positive pregnancy test, including miscarriages, ectopic pregnancies or terminations)?

☐ No

☐ Yes, please complete the table below.

	Pregnancy							
	1st	2nd	3rd	4th	5th	6th	7th	8th
How old were you at the start of the pregnancy?								
(Please write your age at each pregnancy)	.....	.....	.....	.....	.....	.....	.....	.....
What fertility treatment was used, if any, for this pregnancy?								
Natural conception: no fertility treatment								
Fertility drugs by pills to stimulate ovulation (clomid, clomiphene)								
Intrauterine insemination (IUI)								
In vitro fertilization (IVF/ICSI)								
What was the outcome of this pregnancy? *(Please tick ✓ all that apply)*								
Single live birth								
Twins or triplets								
Miscarriage								
Stillbirth								
Termination (abortion)								
Tubal or pregnancy in other location outside the 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								
If this pregnancy resulted in a birth, was the delivery vaginal or via Caesarean section?								
Vaginal birth								
Caesarean section								
Did go into labor and if so, was it induced or did it begin on its own?								
No labor								
Spontaneous labor								
Induced labor								
Did you have any of the following complications related to pregnancy or breast feeding?								
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:								
Other:								
If this 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')	.....	.....	.....	.....	.....	.....	.....	.....

B2. Have you ever tried to get pregnant for more than 6 months in a row without succeeding?

☐ No ☐ Yes

If Yes: B2.1. What was the longest amount of time that you tried, whether or not you actually got pregnant? _____ months

B3. Have you or your partner ever had any tests/investigations to find out why you were not getting pregnant?

☐ No ☐ Yes

If Yes: B3.1. What were the results of these tests? (*Please tick ✓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……

B4. Did you ever seek treatment for infertility in any clinic? ☐ No ☐ Yes

If Yes: B4.1. 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				……..
In vitro fertilization (IVF)				……..
In vitro fertilization with intracytoplasmic sperm injection (ICSI)				……..
In vitro fertilization with eggs from a donor				……..

B4.2 If you ever had IVF, ICSI, or IVF with donor egg(s): After what step did your IVF cycle(s) end?

(please 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 had a pregnancy loss before the end of 12 weeks)
☐ Pregnancy loss or stillbirth after 12 weeks
☐ Live birth

Pain

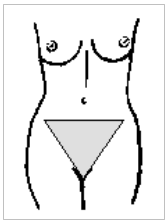
C1. Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint, or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures, or surgery.

We are interested in the types of thoughts and feelings that you have **when 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	☐	☐	☐	☐	☐

The following questions ask about pelvic pain <u>with</u> 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, as shown by the shaded area in this picture:



C2. Has there been a time in your life when you typically had pelvic pain during your periods?

☐ No pain → **Skip to question C15**
☐ Mild cramps (medication never or rarely needed)
☐ Moderate cramps (medication usually needed)
☐ Severe cramps (medication and bed rest needed)

C2.1. At what age did you start having period pain? ___ years

If you have had a period in the last 3 months, please complete the following questions, otherwise, please check here ___ and continue to question C12

C3. How much pelvic pain did you have **during your last period**?

- ☐ No pain → **skip to question C9**
- ☐ Mild cramps (medication never or rarely needed)
- ☐ Moderate cramps (medication usually needed)
- ☐ Severe cramps (medication and bed rest needed)

C4. Did you take any pain-killers for pelvic pain **during your last period**? (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, paracetamol/acetaminophen, naproxen)?

C5. Did you take hormones to help alleviate pelvic pain **during your last period** and if so, did it help to alleviate your pain?

- ☐ Did not take hormones for pain
- ☐ Yes, but pain was not alleviated
- ☐ Yes, pain was at least somewhat alleviated

C6. **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)?

☐ No ☐ Yes

C7. **During your last period,** did you have to lie down for any part of the day or longer because of your pelvic pain? ☐ No ☐ Yes

C8. Please rate how severe your pelvic pain was <u>at its worst</u> **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

C9. **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)

C10. Please rate how severe your pelvic pain during your period was <u>at its worst</u> **in 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

C11. 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?	☐	☐	☐	☐	☐

The following questions are about the time in your life when your pelvic pain during your period was at its worst.

C12. How old were you when your pelvic pain during your period was at its worst? _____ years

C13. Please rate how severe your pelvic pain during your period 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

C14. 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?

(Please check all that apply)

☐ No

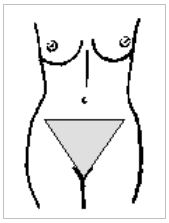
☐ Yes, pain-killers that were prescribed by a doctor

☐ Yes, pain-killers bought over-the-counter without prescription (e.g. aspirin, ibuprofen, paracetamol/acetaminophen, naproxen)?

☐ Yes, hormones, but pain was not alleviated

☐ Yes, hormones, pain was at least somewhat alleviated

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



By 'pelvic pain' we mean any type of pain (cramping, shooting, stabbing, etc.) in the lower part of your belly, as shown by the shaded area in this picture:

We remind you that any information you give will be treated in complete confidence.
*If however you **do not wish to answer these questions**, please check here ___ and skip to question* **C28**

*If you have **never had intercourse**, please check here ___ and skip to question **C27***

C15. Have you ever had pelvic pain during intercourse or in the 24 hours following vaginal sexual intercourse/penetration**?**

☐ No → **Please skip to question C27**

☐ Yes → If yes: C15.1. At what age did this pain start? _____

C16. 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? ☐ No ☐ Yes

If you had vaginal intercourse more than 12 months ago, please skip to question C25

C17. **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 C25**

☐ Yes, during intercourse/penetration

☐ Yes, in the 24 hours following intercourse/penetration

☐ Yes, both during intercourse/penetration and in the 24 hours following

C18. **When you last had vaginal intercourse/penetration**, where did you feel the pain? (tick all that apply)

☐ At the entrance of the vagina

☐ Deep inside the vagina

☐ In the abdomen/pelvis

☐ Other location → If yes: C18.1. Please describe: _____

C19. Please rate how severe your pelvic pain was at its worst **during the last time you had vaginal intercourse/penetration** 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

C20. Please rate how severe your pelvic pain was at its worst **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 imaginable pain.

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

C21. 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)

C22. **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?
C22.1. During a period?	☐ No ☐ Yes	→	☐ No ☐ Yes
C22.2. A few days before a period	☐ No ☐ Yes	→	☐ No ☐ Yes
C22.3. A few days after a period	☐ No ☐ Yes	→	☐ No ☐ Yes
C22.4. At mid cycle (around ovulation)	☐ No ☐ Yes	→	☐ No ☐ Yes

C23. **In the last 12 months**, did you ever **interrupt** vaginal intercourse/penetration because of pelvic pain?

☐ No
☐ Yes

C24. **In the last 12 months**, did you ever **avoid** vaginal intercourse/penetration because of pelvic pain?

☐ No
☐ Yes

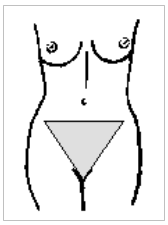
The following questions are about the time in your life when your pain with vaginal intercourse/penetration was at its worst.

C25. How old were you when your pelvic pain with vaginal intercourse/penetration was at its worst? _____ years

C26. 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

The questions in this section ask about pelvic/lower abdominal pain in general.



By 'pelvic pain' we mean any type of pain (cramping, shooting, stabbing, etc.) in the lower part of your belly, as shown by the shaded area in this picture:

*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.*

C27. 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 C40**

☐ Yes → C27.1 At what age did you start having this pelvic pain? ___ years

C27.2 When did you last have this pain?

☐ In the last month
☐ 1-3 months ago
☐ 4-6 months ago
☐ 7-12 months ago → **please skip to question C36**
☐ longer than 12 months ago

C28. To what extent has your 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

C29. Approximately how long in total did you have this pain for **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

C30. Have you taken any medication to help alleviate this pain **in the last 3 months**?

(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, paracetamol/acetaminophen, naproxen)
☐ Yes, hormones, but pain was not alleviated
☐ Yes, hormones, pain was at least somewhat alleviated

C31. 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

C32. 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

C33. 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: _____

C34. 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: _____

C35. 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.*

C36. How old were you when your pelvic/lower abdominal pain was at its worst? _____ years

C37. 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

C38. 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, paracetamol/acetaminophen, naproxen)
- ☐ Yes, hormones, but pain was not alleviated
- ☐ Yes, hormones, pain was at least somewhat alleviated

C39. Have you ever received a diagnosis for the 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)

C40. 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

Medical history

D1. Have you ever been diagnosed by a doctor with cancer or a malignancy of any kind?

☐ No ☐ Yes

If Yes: D1.1. What type(s) of cancer (primary location) have you been diagnosed with, and when were you first diagnosed? *(Please write below)*

Type of Cancer	Age first diagnosed (years)

D2. Have you ever had any of the following medical conditions and if so, at what age you were first diagnosed by a doctor?

Medical Condition			Age diagnosed	Medical Condition			Age diagnosed
No	**Yes**			**No**	**Yes**		
☐	☐	Anxiety requiring medication or therapy		☐	☐	Irritable Bowel Syndrome (IBS)	
☐	☐	Asthma		☐	☐	Migraine	
☐	☐	Cardiovascular disease		☐	☐	Mitral valve prolapse	
☐	☐	Crohn's Disease		☐	☐	Multiple Sclerosis	
☐	☐	Chronic Fatigue Syndrome (CFS) / Myalgic encephalomyelitis (ME)		☐	☐	Painful bladder/interstitial cystitis (NOT bacterial bladder infection)	
☐	☐	Deafness/difficulty hearing		☐	☐	Pelvic Inflammatory Disease (PID)	
☐	☐	Depression requiring medication or therapy		☐	☐	Polycystic Ovary Syndrome	
☐	☐	Diabetes requiring diet control		☐	☐	Rheumatoid Arthritis	
☐	☐	Diabetes requiring insulin or tablets		☐	☐	Scoliosis (curvature of the spine)	
☐	☐	Eczema		☐	☐	Spine problems (excluding scoliosis)	
☐	☐	Fibroid uterus		☐	☐	Sjogren's syndrome	
☐	☐	Fibromyalgia		☐	☐	SLE (Lupus)	
☐	☐	Glandular Fever		☐	☐	Thyroid disease	
☐	☐	Graves' Disease		☐	☐	Ulcerative Colitis	
☐	☐	Hashimoto's disease		☐	☐	Other (*Please specify*):	
☐	☐	High blood pressure				_____	
						_____	
						_____	

D3. Have you been told that you were born with a structural problem / birth defect of your uterus, cervix, or vagina?

- ☐ No
- ☐ Yes → If yes: D3.1. Did you have surgery for this issue?
  - ☐ No
  - ☐ Yes → If Yes: D3.2. Was the problem improved or corrected after surgery?
    - ☐ No
    - ☐ Yes

D4. Have you had any of the following surgical procedures during your life? If so, at approximately what age(s) did you have the procedure(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 (sterilisation/tubes tied)	☐	☐		Age: ……..	
Appendix removed	☐	☐		Age: ……..	
Hysterectomy	☐	☐		Age: ……..	…… ……
Oophorectomy If yes, how many of your ovaries have been removed? ☐ 1 ☐ both ☐ unsure	☐	☐		Age(s): …….. ……	…… ……
Dilatation and Curettage (D&C)	☐	☐		Age(s): …….. ……	…… ……
Cervical surgery (LEEP or conization)	☐	☐		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 you abdomen)	☐	☐			
1st				Age: ……..	…… ……
2nd				Age: ……..	…… ……
3rd				Age: ……..	…… ……
4th				Age: ……..	…… ……
5th or last				Age: ……..	…… ……
Other abdominal surgery: ……	☐	☐		Age(s): …….. ……	…… ……

D5. 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?	☐	☐	☐	☐	☐

D6. 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

D7. 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

D8. Has a doctor or other health care provider ever diagnosed you with endometriosis?

- ☐ No
- ☐ Yes

If Yes:

D8.1. How was the diagnosis made? (check all that apply)

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

D8.2. If you have had surgery for endometriosis, during your most recent surgery was your endometriosis treated (i.e. was it removed or burnt away)?

- ☐ No
- ☐ Yes
- ☐ Unsure
- ☐ Have not had surgery for endometriosis

D8.3. How old were you when you first had symptoms? _____ years old
or tick here ☐ if you never had symptoms

D8.4. What symptoms, if any, prompted you to see a health care provider before your diagnosis with endometriosis?
(please mark all that apply)

- ☐ Pain
- ☐ Infertility
- ☐ No symptoms
- ☐ Other (please specify): _____

D8.5. How old were you when you were diagnosed with endometriosis? _____ years old

D9. Have you ever had surgery to look for endometriosis and none was found?

☐ No
☐ Yes

If yes: D9.1. What symptoms prompted the surgery?

☐ Pain
☐ Infertility
☐ Other (please specify): _____

D10. Have any of your female blood relatives 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

Medication history

E1. 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

E2. Have you EVER taken prescription drugs for more than 3 months, excluding hormone treatments and pain medications?

☐ Yes → please fill out the **Prescription Drug Table below** before proceeding to the next section
☐ No → **please skip to question F1 in the next section**

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: ……	☐	__ __	__ __	☐	

Personal Information and lifestyle

F1. What is your date of birth? __ __ / __ __ / __ __ __ __
DD MM YYYY

F2. How would you describe your ethnic origin?

☐ 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)*

F3. Do you consider yourself to be Spanish/Hispanic/Latina? ☐ No ☐ Yes

F4. 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

F5. Are you currently in school?

☐ No
☐ Yes

F6. 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
☐ Postgraduate

F7. What is your current height? _____ cm or if you prefer, _____ feet _____ inches

F8. What is your current weight? _____ kg or if you prefer, _____ pounds or _____ stones

F9. At age 18, what was your natural hair color? (Please check one). If you are under 18, please tell us what your natural hair color is now.

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

F10. What is your eye color? (Please check one).

- ☐ Blue
- ☐ Gray
- ☐ Green
- ☐ Hazel
- ☐ Brown

F11. 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)										

F12. Have you smoked more than 100 cigarettes during your lifetime?

☐ No

☐ Yes

If yes: F12.1. How old were you when you first started smoking? _____ years old

F12.2. Do you smoke currently?

☐ No, I stopped smoking at age _____

☐ Yes, and I smoke about _____ cigarettes per week

F13. Do you drink any alcohol?

☐ No

☐ Yes

If yes: F13.1. During an average week, how much do you drink of each 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*)	……

F14. Please give the date that you completed this questionnaire: __ __ / __ __ / __ __ __ __

DD MM YYYY

Thank you for your time and cooperation in answering these questions.
If you have comments or questions about any part of this survey, please explain here.

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