Global Study of Women's Health Questionnaire

OVERALL HEALTH

The following questions ask for your views about your health and how you feel about life in general. If you are unsure about how to answer any question, try and think about your overall health and give the best answer you can. Do not spend too much time answering as your immediate response is likely to be the most accurate.

1. In general, would you say your health is:

- o0 Excellent
- o1 Very good
- o2 Good
- o3 Fair
- o4 Poor

2. Compared to one year ago, how would you rate your health in general **now**?

- o0 Much better than one year ago
- o1 Somewhat better than one year ago
- o2 About the same
- o3 Somewhat worse now than one year ago
- o4 Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does **your health** limit you in these activities? If so, how much?

	Yes, limited A lot	**Yes, limited a little**	**No, not limited at all**
a. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	o0	o1	o2
b. **Moderate activities**, such as moving a table, pushing a vacuum, bowling or playing golf	o0	o1	o2
c. Lifting or carrying groceries	o0	o1	o2
d. Climbing **several** flights of stairs	o0	o1	o2
e. Climbing **one** flight of stairs	o0	o1	o2
f. Bending, kneeling or stooping	o0	o1	o2
g. Walking **more than a mile**	o0	o1	o2
h. Walking **half a mile**	o0	o1	o2
i. Walking **100 yards**	o0	o1	o2
j. Bathing and dressing yourself	o0	o1	o2

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the **amount of time** you spent on work and other activities	o0	o1	o2	o3	o4
b. **Accomplished less** than you would like	o0	o1	o2	o3	o4
c. Were limited in the **kind** of work or other activities	o0	o1	o2	o3	o4
d. Had difficulty performing the work or other activities (e.g. it took more effort)	o0	o1	o2	o3	o4

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the **amount of time** you spent on work and other activities	o0	o1	o2	o3	o4
b. **Accomplished less** than you would like	o0	o1	o2	o3	o4
c. Did work or other activities **less carefully than usual**	o0	o1	o2	o3	o4

6. During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, neighbours or groups?

- o0 Not at all
- o1 Slightly
- o2 Moderately
- o3 Quite a bit
- o4 Extremely

7. How much **bodily pain** have you had during the **past 4 weeks**?

- o0 None
- o1 Very mild
- o2 Mild
- o3 Moderate
- o4 Severe
- o5 Very severe

8. During the past 4 weeks, how much did **pain** interfere with your normal work (including both outside the home and housework)?

- o_0 Not at all
- o_1 Slightly
- o_2 Moderately
- o_3 Quite a bit
- o_4 Extremely

9. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give one answer that comes closest to the way you have been feeling.

How much time during the last 4 weeks…..:

		All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a.	Did you feel full of life?	o_0	o_1	o_2	o_3	o_4
b.	Have you been very nervous?	o_0	o_1	o_2	o_3	o_4
c.	Have you felt so down in the dumps that nothing would cheer you up?	o_0	o_1	o_2	o_3	o_4
d.	Have you felt calm and peaceful?	o_0	o_1	o_2	o_3	o_4
e.	Did you have a lot of energy?	o_0	o_1	o_2	o_3	o_4
f.	Have you felt downhearted and low?	o_0	o_1	o_2	o_3	o_4
g.	Did you feel worn out?	o_0	o_1	o_2	o_3	o_4
h.	Have you been happy?	o_0	o_1	o_2	o_3	o_4
i.	Did you feel tired?	o_0	o_1	o_2	o_3	o_4

10. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc)

- o_0 All of the time
- o_1 Most of the time
- o_2 Some of the time
- o_3 A little of the time
- o_4 None of the time

11. How TRUE or FALSE is **each** of the following statements for you?

	Definitely true	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
a. I seem to get ill more easily than other people	o_0	o_1	o_2	o_3	o_4
b. I am as healthy as anybody I know	o_0	o_1	o_2	o_3	o_4
c. I expect my health to get worse	o_0	o_1	o_2	o_3	o_4
d. My health is excellent	o_0	o_1	o_2	o_3	o_4

MEDICAL BACKGROUND

12. What symptom(s) led to your planned gynaecological surgery? At what age, approximately, did this/these symptoms **first** start?

(Please tick all that apply)

	NO	YES	If Yes, Symptom started at age:
No symptoms: attending for sterilisation	o0	o1	→ **GO TO QUESTION 16**
Pelvic pain	o0	o1	……yr
Pelvic mass	o0	o1	……yr
Painful periods	o0	o1	……yr
Heavy periods	o0	o1	……yr
Infertility	o0	o1	……yr
Ovarian cyst	o0	o1	……yr
Painful intercourse	o0	o1	……yr
Pain on opening bowels	o0	o1	……yr
Bleeding from back passage when opening bowels	o0	o1	……yr
Bowel upset e.g.: constipation, diarrhoea	o0	o1	……yr
Pain on passing urine	o0	o1	……yr
Blood in urine	o0	o1	……yr
Other urinary problems	o0	o1	……yr
Other *(please specify:)* ……..	o0	o1	……yr

13. How old were you when you ***first*** sought medical advice for any of the above symptoms? ……. years old

14. *Approximately* how many times have you seen your GP for any of the symptoms in question 12 (counting from when they first started) **before you were first referred to a specialist**?

…….. times

15. Besides your current gynaecologist, has your GP ever referred you to other specialists for your symptoms? *(for example: another gynaecologist, gastro-enterologist (bowel specialist), urologist (bladder specialist), genito-urinary specialist (STD clinic), or physiotherapist)?*

o0 No → ***If No: GO TO QUESTION 16***
o1 Yes →

If Yes:
What type(s) of specialist did you see, in what year was the first referral to this specialist, and what diagnosis were you given?

Please add as many specialists and diagnoses as apply to your situation (on a separate sheet if necessary).

Referral number:	**Type of specialist:**	**Year of first referral:**	**Diagnosis given (if any):**
Referral 1	o0 another gynaecologist o1 gastro-enterologist o2 urologist o3 genito-urinary clinic o4 physiotherapist o5 other ***(please specify):*** ……	…….	……..…… ……..… ……..…

MENSTRUAL HISTORY AND CONTRACEPTION

16. At what age did you have your **first** period? ……. years old

17. Have you used hormonal contraception at any time **in the last 3 months**? **(e.g. the Pill, hormonal injections/patches, or Mirena)**?

o0 No **If No**: GO TO QUESTION 18

o1 Yes **If Yes:**

a. What are/were your reasons for using hormonal contraception? ***(please tick all that apply)***

o0 Contraception
o1 Pelvic pain
o2 Irregularity of periods
o3 Heavy periods
o4 Other: ……. ……. *(please specify)*

b. What type of hormonal contraception have you used most recently?

o0 A pill/tablet
o1 A skin patch
o2 Injections
o3 Implant
o4 A vaginal ring
o5 An IUCD/coil

……. *(please give the name)*

c. How long ago did you start using this hormonal product?

o0 Less than 3 months ago
o1 3-6 months ago
o2 7-12 months ago
o3 1-5 years ago
o4 More than 5 years ago

d. Are you still using this hormonal product?

o0 No
o1 Yes

e. When was the last time you had a natural period (i.e. when not on hormonal contraception?)

o0 I have never had a natural period
o1 Less than 3 months ago
o2 Between 3 and 12 months ago
o3 Between 1 and 5 years ago
o4 More than 5 years ago

18. Have you had a period **in the last 3 months?** *(either natural periods or withdrawal bleeds whilst on hormonal contraception)*

o0 No **If No:** GO TO QUESTION 19

o1 Yes **If Yes:**

Please answer questions a to e about your periods **in the last 3 months:**

a. Are your periods **regular?** *(predictable within one week)*

o0 No
o1 Yes

b. How many days of bleeding do you usually have each period?
(we mean bleeding for which you needed a tampon or sanitary pad, NOT discharge for which you needed a pantyliner only)

…….. days o0 Too irregular to say

c. How heavy is your menstrual flow usually?

o0 Light
o1 Moderate
o2 Heavy *(clots/flooding)*
o3 Can't remember

d. How many days are there between the start of one period and the start of the next **on average**?

o0 Less than 21 days
o1 22-24 days
o2 25-28 days
o3 29-32 days
o4 33 – 35 days
o5 More than 36 days
o6 Too irregular to say

e. Do you have any of the following symptoms when you have a period?

Please tick all that apply

o0 Pelvic pain (pain in the lower party of your belly)
o1 Pain on opening your bowels
o2 Bleeding from your back passage when opening your bowels
o3 Pain on passing urine
o4 Passing blood in your urine
o5 Lower back pain
o6 Pain in upper leg or thighs
o7 Nausea
o8 Tiredness

19. When you were in ***each*** of the following age groups, what were your periods like when you were **NOT using hormonal contraception**?

(Please give answers that apply to you as closely as possible, or otherwise indicate that you cannot remember).

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Did you have natural periods? *(not on hormonal contraception)*	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes
Were your periods regular? *(predictable within one week)*	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember
How many days of bleeding did you usually have each period? *(we mean bleeding for which you needed a tampon or sanitary pad, NOT discharge for which you needed a pantyliner only)*	….. days *or tick :* o0 Too irregular to say o1 Can't remember	….. days *or tick :* o0 Too irregular to say o1 Can't remember	….. days *or tick :* o0 Too irregular to say o1 Can't remember	….. days *or tick :* o0 Too irregular to say o1 Can't remember	….. days *or tick :* o0 Too irregular to say o1 Can't remember
How heavy was your menstrual flow usually?	o0 Light o1 Moderate o2 Heavy *(clots/flooding)* o3 Can't remember	o0 Light o1 Moderate o2 Heavy *(clots/flooding)* o3 Can't remember	o0 Light o1 Moderate o2 Heavy *(clots/flooding)* o3 Can't remember	o0 Light o1 Moderate o2 Heavy *(clots/flooding)* o3 Can't remember	o0 Light o1 Moderate o2 Heavy *(clots/flooding)* o3 Can't remember
On average, how many days were there between the start of one period and the start of the next?	o0 Less than 24 days o1 24-38 days o2 More than 38 days o3 Too irregular to say o4 Can't remember	o0 Less than 24 days o1 24-38 days o2 More than 38 days o3 Too irregular to say o4 Can't remember	o0 Less than 24 days o1 24-38 days o2 More than 38 days o3 Too irregular to say o4 Can't remember	o0 Less than 24 days o1 24-38 days o2 More than 38 days o3 Too irregular to say o4 Can't remember	o0 Less than 24 days o1 24-38 days o2 More than 38 days o3 Too irregular to say o4 Can't remember

20. For ***each*** of the following age groups, please answer the following questions about the sanitary protection you used.

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Did you use sanitary pads? *(not counting pantyliners)*	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember
Did you use tampons?	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 No o1 Occasionally o2 Often o3 Always o4 Can't remember
How often did you sleep with a tampon in place at night ?	o0 Never o1 1 or 2 nights each period o2 3 or 4 nights each period o3 5 or more nights each period o4 Can't remember	o0 Never o1 1 or 2 nights each period o2 3 or 4 nights each period o3 5 or more nights each period o4 Can't remember	o0 Never o1 1 or 2 nights each period o2 3 or 4 nights each period o3 5 or more nights each period o4 Can't remember	o0 Never o1 1 or 2 nights each period o2 3 or 4 nights each period o3 5 or more nights each period o4 Can't remember	o0 Never o1 1 or 2 nights each period o2 3 or 4 nights each period o3 5 or more nights each period o4 Can't remember

21. For each of the following age groups, please indicate whether you ever had sexual intercourse while you were having a period.

IF YOU DO NOT WISH TO ANSWER THIS QUESTION PLEASE TICK HERE: o0 AND GO TO QUESTION 22

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Did you have sexual intercourse while having a period?	o0 Never o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 Always o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 Always o4 Can't remember

22. For ***each*** of the following age groups, please indicate what type of contraception you used, and give the ***approximate*** ages you started and stopped. If you used hormonal contraceptives for menstrual or other symptoms, please include this.

IF YOU DO NOT WISH TO ANSWER THIS QUESTION PLEASE TICK HERE: o0 AND SKIP TO QUESTION 24

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Did you use an Intra-uterine Device (IUD/coil)?	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember
Did you use a diaphragm?	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember
Did you use any hormonal contraception? *(e.g. the oral contraceptive pill or injections)*	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember	o0 No o1 Yes, from age ….. to ….. yrs o2 Can't remember
Did you (or your partner) use a condom?	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember	o0 No o1 Yes o2 Can't remember
Did you use other methods of contraception? If so, please specify what type(s)	o0 No o1 Yes: ……... …… o2 Can't remember	o0 No o1 Yes: ……... …… o2 Can't remember	o0 No o1 Yes: ……... …… o2 Can't remember	o0 No o1 Yes: ……... …… o2 Can't remember	o0 No o1 Yes: ……... …… o2 Can't remember

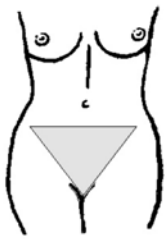
23. For each of the following age groups (until the age you are now), please indicate whether you ever used the Morning-after Pill. If so, how many times?

IF YOU DO NOT WISH TO ANSWER THIS QUESTION PLEASE TICK HERE: o0 AND SKIP TO QUESTION 24

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Did you ever use the Morning-after Pill?	o0 No o1 Yes: ….. times	o0 No o1 Yes: ….. times	o0 No o1 Yes: ….. times	o0 No o1 Yes: ….. times	o0 No o1 Yes: ….. times

PELVIC PAIN

By 'pelvic pain' we mean any type of pain in the lower part of your belly (the area from your navel down) as shown by the shaded area in this picture:



24. In the last 3 months, have you had **pelvic pain with your periods**?

o0 No → ***If No: Please skip to question 26***

o1 Yes

a. How often have you had pelvic pain with your periods **in the last 3 months**?

- o0 Occasionally *(with 1 in 3 of my periods)*
- o1 Often *(with 2 in 3 of my periods)*
- o2 Always *(with every period)*

b. In the last 3 months, have you taken pain-killers for the pain that are prescribed for you by a doctor?

- o0 No
- o1 Yes

c. In the last 3 months, have you taken pain-killers for the pain, bought over the counter without prescription?

- o0 No
- o1 Yes

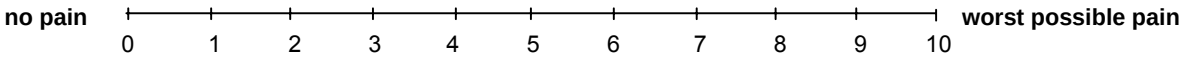
d. In the last 3 months, has your period pain prevented you from going to work or carrying out your daily activities *(even if taking pain-killers)* ?

- o0 Never
- o1 Occasionally *(with 1 in 3 of my periods)*
- o2 Often *(with 2 in 3 of my periods)*
- o3 Always *(with every period)*

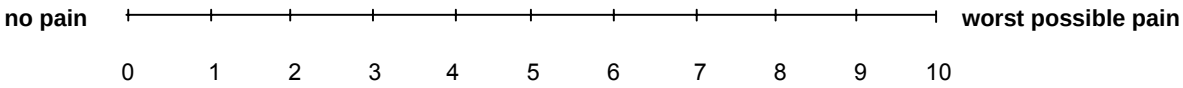
e. In the last 3 months, have you had to lie down for any part of the day or longer because of your period pain?

- o0 Never
- o1 Occasionally *(with 1 in 3 of my periods)*
- o2 Often *(with 2 in 3 of my periods)*
- o3 Always *(with every period)*

f. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your period pain has been **ON AVERAGE in the last 3 months**:



g. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your period pain has been **AT ITS WORST in the last 3 months**:



h. The following questions are about your bowel movements/stool **when you had period pain IN THE LAST 3 MONTHS**

<u>When you had period pain in the last 3 months…..</u>	**Never/ Rarely**	**Sometimes**	**Often**	**Most of the time**	**Always**
…. how often did this pain get better or stop after you had a bowel movement?	O_0	O_1	O_2	O_3	O_4
…. how often did you have more frequent bowel movements?	O_0	O_1	O_2	O_3	O_4
…. how often did you have less frequent bowel movements?	O_0	O_1	O_2	O_3	O_4
…. were your stools (bowel movements) *looser*?	O_0	O_1	O_2	O_3	O_4
…. were your stools (bowel movements) *harder* ?	O_0	O_1	O_2	O_3	O_4

25. For ***each*** of the following age groups, please indicate **what your period pain was like**:

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
On average, how often did you have painful periods?	o$_0$ Never o$_1$ Occasionally *(with less than a quarter of my periods)* o$_2$ Often *(with a quarter to half my periods)* o$_3$ Usually *(with more than half my periods)* o$_4$ Always *(with every period)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(with less than a quarter of my periods)* o$_2$ Often *(with a quarter to half my periods)* o$_3$ Usually *(with more than half my periods)* o$_4$ Always *(with every period)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(with less than a quarter of my periods)* o$_2$ Often *(with a quarter to half my periods)* o$_3$ Usually *(with more than half my periods)* o$_4$ Always *(with every period)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(with less than a quarter of my periods)* o$_2$ Often *(with a quarter to half my periods)* o$_3$ Usually *(with more than half my periods)* o$_4$ Always *(with every period)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(with less than a quarter of my periods)* o$_2$ Often *(with a quarter to half my periods)* o$_3$ Usually *(with more than half my periods)* o$_4$ Always *(with every period)* o$_5$ Can't remember
Did you take pain-killers prescribed for you by a doctor?	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes
Did you take pain-killers that you bought over the counter *(without prescription)*?	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes
Did your period pain prevent you from going to work or carrying out your daily activities *(even if taking pain-killers)* **?**	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember
Did you have to lie down for any part of the day or longer because of your period pain?	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember	o$_0$ Never o$_1$ Occasionally o$_2$ Often o$_3$ Always o$_4$ Can't remember

THE FOLLOWING QUESTIONS ARE ABOUT PAIN DURING OR AFTER SEXUAL INTERCOURSE.
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 TICK HERE: o0 AND GO TO QUESTION 28

IF YOU **HAVE NEVER HAD** SEXUAL INTERCOURSE, PLEASE TICK HERE: o0 AND GO TO QUESTION 28

26. In the last 3 months, have you had pelvic pain **during or in the 24 hours after sexual intercourse**?

o0 Not applicable: I have not had sexual intercourse in the last 3 months → ***GO TO QUESTION 28***
o1 No
o2 Yes

If Yes:

a. On average, **how often** do you have pelvic pain during or in the 24 hours after intercourse?

o0 Never
o1 Occasionally *(less than a quarter of the times)*
o2 Often *(a quarter to half of the times)*
o3 Usually *(more than half of the times)*
o4 Always *(every time)*
o5 Can't remember

b. Do you ever **interrupt** intercourse because of pelvic pain**?**

o0 No
o1 Yes

c. Do you ever **avoid** intercourse because of pelvic pain**?**

o0 No
o1 Yes

d. Is there a time of the month in which intercourse is more painful than at other times?

Please tick all that apply

o0 No
o1 Yes: during a period
o2 Yes: just before or after a period
o3 Yes: at mid-cycle (around ovulation)

e. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your pain **during** sexual intercourse has been **ON AVERAGE in the last 3 months**:

no pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 **worst possible pain**

f. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your pain **in the 24 hours after** sexual intercourse has been **ON AVERAGE in the last 3 months**:

no pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 **worst possible pain**

27. For ***each*** of the following age groups, please indicate what your pain with intercourse was like:

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
	o$_0$ I did not have intercourse	o$_0$ I did not have intercourse	o$_0$ I did not have intercourse	o$_0$ I did not have intercourse	o$_0$ I did not have intercourse
On average, how often did you have pelvic pain during or in the 24 hours after intercourse?	o$_0$ Never o$_1$ Occasionally *(less than a quarter of the times)* o$_2$ Often *(a quarter to half of the times)* o$_3$ Usually *(more than half of the times)* o$_4$ Always *(every time)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(less than a quarter of the times)* o$_2$ Often *(a quarter to half of the times)* o$_3$ Usually *(more than half of the times)* o$_4$ Always *(every time)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(less than a quarter of the times)* o$_2$ Often *(a quarter to half of the times)* o$_3$ Usually *(more than half of the times)* o$_4$ Always *(every time)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(less than a quarter of the times)* o$_2$ Often *(a quarter to half of the times)* o$_3$ Usually *(more than half of the times)* o$_4$ Always *(every time)* o$_5$ Can't remember	o$_0$ Never o$_1$ Occasionally *(less than a quarter of the times)* o$_2$ Often *(a quarter to half of the times)* o$_3$ Usually *(more than half of the times)* o$_4$ Always *(every time)* o$_5$ Can't remember
Did you ever <u>interrupt</u> intercourse because of pelvic pain?	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes
Did you ever <u>avoid</u> intercourse because of pelvic pain?	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes	o$_0$ No o$_1$ Yes
Was your pelvic pain with intercourse <u>worse</u> when you had a period?	o$_0$ No o$_1$ Yes o$_2$ N/A: I never had intercourse while having a period o$_3$ Can't remember	o$_0$ No o$_1$ Yes o$_2$ N/A: I never had intercourse while having a period o$_3$ Can't remember	o$_0$ No o$_1$ Yes o$_2$ N/A: I never had intercourse while having a period o$_3$ Can't remember	o$_0$ No o$_1$ Yes o$_2$ N/A: I never had intercourse while having a period o$_3$ Can't remember	o$_0$ No o$_1$ Yes o$_2$ N/A: I never had intercourse while having a period o$_3$ Can't remember

28. In the last 3 months, have you had pelvic pain **at times OTHER than with periods or intercourse**?

o0 No ⟶ ***If No: GO TO QUESTION 30***
o1 Yes

If Yes:

a. How long ago did this pain **first** start**?**

o0 0 to 3 months ago
o1 4-6 months ago
o2 7-12 months ago
o3 Between 1 and 5 years ago
o4 More than 5 years ago: ⟶ ….. years ago

b. Do you usually have this pain **at about the same time in your cycle**?

Please tick all that apply

o0 No
o1 Yes, just before a period
o2 Yes, just after a period
o3 Yes, at mid-cycle (ovulation)

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

o0 Less than one day a month
o1 One day a month
o3 2-3 days a month
o4 One day a week
o5 More than one day a week
o6 Every day

d. Do you take pain-killers for this pain, prescribed for you by a doctor?

o0 No
o1 Yes

e. Do you take pain-killers for this pain that you can buy without a prescription? *(e.g. Aspirin, Nurofen, Paracetamol)*

o0 No
o1 Yes

f. Have you ever been admitted to hospital for your pain?

o0 No
o1 Yes

g. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your pain **at times OTHER than with periods or intercourse** has been **ON AVERAGE in the last 3 months**:

no pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

h. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your pain **at times OTHER than with periods or intercourse** has been **AT ITS WORST in the last 3 months**:

no pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

i. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your pain was **AT ITS WORST during your last internal gynaecological examination:**

no pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

j. The following questions are about your bowel movements/stool **when you had pelvic pain OTHER than with periods IN THE LAST 3 MONTHS**

When you had pelvic pain OTHER than with periods in the last 3 months…..	**Never/ Rarely**	**Sometimes**	**Often**	**Most of the time**	**Always**
…. how often did this pain get better or stop after you had a bowel movement?	O_0	O_1	O_2	O_3	O_4
…. how often did you have more frequent bowel movements?	O_0	O_1	O_2	O_3	O_4
…. how often did you have less frequent bowel movements?	O_0	O_1	O_2	O_3	O_4
…. were your stools (bowel movements) *looser*?	O_0	O_1	O_2	O_3	O_4
…. were your stools (bowel movements) *harder* ?	O_0	O_1	O_2	O_3	O_4

k. The following questions are about your bowel movements/stool **IN GENERAL in the last 3 months.**

In the last 3 months…..	**Never/ Rarely**	**Sometimes**	**Often**	**Most of the time**	**Always**
…. did you have *loose, mushy, or watery* stools?	O_0	O_1	O_2	O_3	O_4
…. did you have *hard or lumpy* stools?	O_0	O_1	O_2	O_3	O_4

I. The following questions are about **urination in the last 3 months**

In the last 3 months…..	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
… how often have you had a sensation of *not emptying your bladder completely* after you finished urinating?	o0	o1	o2	o3	o4	o5
…. how often have you had to urinate again *less than two hours* after you finished urinating?	o0	o1	o2	o3	o4	o5
…. how often have you found it *difficult to postpone* urination?	o0	o1	o2	o3	o4	o5
…. have you felt *'stinging'* on passing urine?	o0	o1	o2	o3	o4	o5
…. how often have you had *pelvic pain <u>during</u>* urination?	o0	o1	o2	o3	o4	o5
…. how often have you had *pelvic pain after <u>you finished</u>* urination?	o0	o1	o2	o3	o4	o5
…. how often did pelvic pain with urination *increase just before a period*?	o0	o1	o2	o3	o4	o5
…. how many times did you typically *get up to urinate* from the time you went to bed at night until the time you got up in the morning?	**None** o0	**1 time** o1	**2 times** o2	**3 times** o3	**4 times** o4	**5 or more times** o5

29. For ***each*** of the following age groups, please indicate what your pelvic pain **at times OTHER than with periods or intercourse** was like:

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
How often did you have pelvic pain at times other than with periods or intercourse?	o0 Never o1 Occasionally o2 Often o3 (Almost) constantly o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 (Almost) constantly o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 (Almost) constantly o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 (Almost) constantly o4 Can't remember	o0 Never o1 Occasionally o2 Often o3 (Almost) constantly o4 Can't remember
Did you take pain-killers prescribed for you by a doctor?	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes
Did you take pain-killers that you can buy without a prescription? *(e.g. Aspirin, Nurofen, Paracetamol)*	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes
Were you ever admitted to hospital for your pain?	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes	o0 No o1 Yes

PREGNANCY HISTORY

30. Have you ever been pregnant (including miscarriages, ectopics or terminations)?

(An ectopic pregnancy is a pregnancy that has implanted outside of the womb, most commonly in the fallopian tubes)

IF YOU **DO NOT WISH TO ANSWER** THESE QUESTIONS, PLEASE TICK HERE: o$_0$ AND SKIP TO QUESTION 32

o$_0$ No → ***if No: GO TO QUESTION 32***
o$_1$ Yes ↓

If Yes:
Please answer the following questions for ***each*** of your pregnancies:

	PREGNANCY:					
	1st	**2nd**	**3rd**	**4th**	**5th**	**6th**
How old were you at the start of the pregnancy?	…... years old	…... years old	…... years old	…... years old	…... years old	…... years old
What was the outcome of this pregnancy?	o$_0$ Live birth o$_1$ Still birth o$_2$ Ectopic pregnancy o$_3$ Miscarriage o$_4$ Termination (abortion)	o$_0$ Live birth o$_1$ Still birth o$_2$ Ectopic pregnancy o$_3$ Miscarriage o$_4$ Termination (abortion)	o$_0$ Live birth o$_1$ Still birth o$_2$ Ectopic pregnancy o$_3$ Miscarriage o$_4$ Termination (abortion)	o$_0$ Live birth o$_1$ Still birth o$_2$ Ectopic pregnancy o$_3$ Miscarriage o$_4$ Termination (abortion)	o$_0$ Live birth o$_1$ Still birth o$_2$ Ectopic pregnancy o$_3$ Miscarriage o$_4$ Termination (abortion)	o$_0$ Live birth o$_1$ Still birth o$_2$ Ectopic pregnancy o$_3$ Miscarriage o$_4$ Termination (abortion)
How many weeks were you pregnant for? (Full term = 40 wks)	o$_0$ less than 37 o$_1$ 37 or more	o$_0$ less than 37 o$_1$ 37 or more	o$_0$ less than 37 o$_1$ 37 or more	o$_0$ less than 37 o$_1$ 37 or more	o$_0$ less than 37 o$_1$ 37 or more	o$_0$ less than 37 o$_1$ 37 or more
If this pregnancy resulted in a birth, was the delivery vaginal or via Caesarean section?	o$_0$ Vaginal birth o$_1$ Caesarean o$_2$ Not applicable	o$_0$ Vaginal birth o$_1$ Caesarean o$_2$ Not applicable	o$_0$ Vaginal birth o$_1$ Caesarean o$_2$ Not applicable	o$_0$ Vaginal birth o$_1$ Caesarean o$_2$ Not applicable	o$_0$ Vaginal birth o$_1$ Caesarean o$_2$ Not applicable	o$_0$ Vaginal birth o$_1$ Caesarean o$_2$ Not Applicable
If this pregnancy resulted in a birth, what was your baby's sex?	o$_0$ Male o$_1$ Female o$_2$ Not applicable	o$_0$ Male o$_1$ Female o$_2$ Not applicable	o$_0$ Male o$_1$ Female o$_2$ Not applicable	o$_0$ Male o$_1$ Female o$_2$ Not applicable	o$_0$ Male o$_1$ Female o$_2$ Not applicable	o$_0$ Male o$_1$ Female o$_2$ Not Applicable
If this pregnancy resulted in a birth, what was your baby's birthweight?	…. lbs & …. oz *or:* ……….. grams *or tick :* o$_0$ Not applicable o$_1$ Can't remember	…. lbs & …. oz *or:* ……….. grams *or tick :* o$_0$ Not applicable o$_1$ Can't remember	…. lbs & …. oz *or:* ……….. grams *or tick :* o$_0$ Not applicable o$_1$ Can't remember	…. lbs & …. oz *or:* ……….. grams *or tick :* o$_0$ Not applicable o$_1$ Can't remember	…. lbs & …. oz *or:* ……….. grams *or tick :* o$_0$ Not applicable o$_1$ Can't remember	…. lbs & …. oz *or:* ……….. grams *or tick :* o$_0$ Not applicable o$_1$ Can't Remember
If this pregnancy resulted in a live birth, did you breastfeed your child? If so, for how long?	o$_0$ No o$_1$ Yes: for ….. months o$_2$ Not applicable	o$_0$ No o$_1$ Yes: for ….. months o$_2$ Not applicable	o$_0$ No o$_1$ Yes: for ….. months o$_2$ Not applicable	o$_0$ No o$_1$ Yes: for ….. months o$_2$ Not applicable	o$_0$ No o$_1$ Yes: for ….. months o$_2$ Not applicable	o$_0$ No o$_1$ Yes: for ….. months o$_2$ Not applicable

IF YOU HAVE NEVER HAD A LIVE BIRTH, PLEASE SKIP TO QUESTION 32

31. After the birth of your **last** child and **after you stopped breastfeeding**, were your menstrual cycles different in any way compared to before you became pregnant with your first child?

(Please mark all that apply)

- o0 No change
- o1 Periods more regular
- o2 Periods less regular
- o3 Periods more painful
- o4 Periods less painful
- o5 Duration of flow shorter
- o6 Duration of flow longer
- o7 Flow heavier
- o8 Flow lighter
- o9 Can't remember

32. Have you ever tried to get pregnant for more than 12 consecutive months without success?

- o0 No ⟶ ***If No: GO TO QUESTION 35***
- o1 Yes

33. Did you or your partner have any test(s) to discover the cause of the fertility problem?

- o0 No ⟶ ***If No: GO TO QUESTION 35***
- o1 Yes

If Yes:
What were you or your partner diagnosed with? ***(Please mark all that apply)***

- o0 Endometriosis
- o1 Polycystic ovaries
- o2 Pelvic inflammatory disease / Pelvic infection
- o3 Uterine fibroids
- o4 Blocked tubes
- o5 No or irregular ovulation
- o6 Poor sperm count or quality
- o7 Other problem ***(please write):*** ……..

34. Have you ever had any treatment to help you to become pregnant (e.g. ovulation stimulants, donor insemination, in vitro fertilisation [IVF])?

- o0 No ⟶ ***If No: GO TO QUESTION 35***
- o1 Yes

If Yes:

a. Have you had any of the following treatments? ***(Please mark all that apply)***

- o0 Clomiphene (Clomid)
- o1 Gonadotrophins (e.g. Pergonal, Metrodin, Puregon, Gonal F)
- o2 Donor insemination
- o3 In vitro fertilization (IVF) or Intra-cytoplasmic Sperm Injection (ICSI)
- o4 Gamete intrafallopian transfer (GIFT)
- o5 Intra uterine insemination
- o6 Other ***(please write):*** …….

b. What is the current status of your fertility therapy?

- o0 Still trying
- o1 No longer trying

MEDICAL AND FAMILY HISTORY

35. Do you know what your weight at birth was?

- o0 No
- o1 Yes ⟶ my birth weight was …….. lbs ……..... oz (*or:* ……..… grams)

36. What is your current weight? ……..... st …….. lbs (*or:* ……..… lbs) (*or:* ……..…. kg)

37. How tall are you? …… feet ……..... inches (*or:* ……..... metres)

38. What would you say your **natural** hair colour is?

- o0 Fair or Blonde
- o1 Light Brown
- o2 Light Red or Ginger
- o3 Auburn or Dark Red
- o4 Medium Brown
- o5 Dark Brown
- o6 Black

39. From the list below please mark whether you have had any of the following medical conditions, and at what age you were first diagnosed.

	NO	**YES**	**If Yes, first diagnosed at age:**
Asthma	o0	o1	…… yrs
Breast Cancer	o0	o1	…… yrs
Chronic Fatigue Syndrome (M.E.)	o0	o1	…… yrs
Deafness or difficulty hearing	o0	o1	…… yrs
Depression requiring medication or medical consultation	o0	o1	…… yrs
Diabetes requiring insulin or tablets	o0	o1	…… yrs
Eczema	o0	o1	…… yrs
Fibroid uterus	o0	o1	…… yrs
Fibromyalgia	o0	o1	…… yrs
Glandular Fever	o0	o1	…… yrs
Hashimoto's disease	o0	o1	…… yrs
Incomplete opening of the vagina (imperforate hymen)	o0	o1	…… yrs
Lymphoma – Hodgkin's	o0	o1	…… yrs
Lymphoma – Non-Hodgkin's	o0	o1	…… yrs
Melanoma	o0	o1	…… yrs
Multiple Sclerosis	o0	o1	…… yrs
Ovarian Cancer	o0	o1	…… yrs
Ovarian Cysts (benign)	o0	o1	…… yrs
Polycystic Ovary Syndrome	o0	o1	…… yrs
Pyloric Stenosis	o0	o1	…… yrs
Rheumatoid Arthritis	o0	o1	…… yrs
Scoliosis (curvature of the spine)	o0	o1	…… yrs
Other spine problems	o0	o1	…… yrs
Sjogren's syndrome	o0	o1	…… yrs
Thyroid disease	o0	o1	…… yrs
Mitral valve prolapse	o0	o1	…… yrs
SLE (Lupus)	o0	o1	…… yrs
Migraine	o0	o1	…… yrs
Other ***(please specify:)*** ……	o0	o1	…… yrs

40. 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) for the first time, and how many have you had in total?

	NO	YES	If Yes:	
			At what age for the first time?	How many times in total?
Dilatation and Curettage (D&C)	o0	o1	…… yrs	……..… times
Gallbladder surgery	o0	o1	…… yrs	……..… times
Hernia operation	o0	o1	…… yrs	……..… times
Laparoscopy (surgery involving insertion of a telescope into your abdomen)	o0	o1	…… yrs	……..… times
Sigmoidoscopy/colonoscopy (insertion of a tube to look inside your bowel)	o0	o1	…… yrs	……..… times
Hysterectomy	o0	o1	…… yrs	
Tubal ligation (sterilisation/tubes tied)	o0	o1	…… yrs	
Appendix removed	o0	o1	…… yrs	
Other abdominal surgery ***(please specify)***: …….. …….. ……..	o0	o1	…… yrs	……..… times

41. Are you allergic to anything?

o0 No
o1 Yes *(Please specify:)* ……

42. Did your mother use the drug DES (diethylstilbestrol) when she was pregnant with you?

o0 No
o1 Yes
o2 Don't know

43. Did a doctor ever say that you had a double or divided uterus?

o0 No
o1 Yes
o2 Not sure

44. Did a doctor ever say your uterus was retroverted or bent backwards?

o0 No
o1 Yes
o2 Not sure

45. Did you ever have an abnormal cervical smear test or other cervical problem that required freezing, burning, or surgery (conization) of the cervix?

o0 No ⟶ ***If No: GO TO QUESTION 46***
o1 Yes

If Yes:

a. please check what type and when you ***first*** had such treatment

o0 Freezing (cryocautery): at ……..years old
o1 Electrocautery or laser: at ……..years old
o2 Conization: at ……..years old

b. Did your menstrual cycles change in any way, after the cervical procedure? ***(Please mark all that apply)***

- o0 No change
- o1 Periods more regular
- o2 Periods less regular
- o3 Periods more painful
- o4 Periods less painful
- o5 Duration of flow shorter
- o6 Duration of flow longer
- o7 Flow heavier
- o8 Flow lighter
- o9 Can't remember

46. Moles are brown or black spots on the skin which usually start in childhood. They may be **flat** (cannot be felt) or **raised** (can be felt). Moles are usually **darker** and **larger** than freckles. Moles usually **appear on their own**, whereas freckles appear in groups.

Note: A spot that looks like a freckle but is on its own and cannot be felt is most likely a mole.

How many moles do you have, approximately?

- o0 No moles
- o1 1 to 10 moles
- o2 11 to 50 moles
- o3 More than 50 moles

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

- o0 No ⟶ ***If No: GO TO QUESTION 48***
- o1 Yes

If Yes:

a. How old were you when you first started smoking? ….. years old

b. Do you smoke currently?
- o0 No, I stopped …… weeks/months/years ago (please specify)
- o1 Yes, I smoke about …… cigarettes a week

c. For ***each*** of the following age groups, please state whether or not you smoked cigarettes, and give the ***approximate*** ages you started and stopped (if you did):

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Did you smoke cigarettes?	o0 No o1 Yes, from age ..… to …... yrs	o0 No o1 Yes, from age ..… to …... yrs	o0 No o1 Yes, from age ..… to …... yrs	o0 No o1 Yes, from age ..… to …... yrs	o0 No o1 Yes, from age ..… to …... yrs
On average, how many cigarettes did you smoke <u>per week</u>?	About …….. cigarettes/week *or tick :* o0 Can't remember	About …….. cigarettes/week *or tick :* o0 Can't remember	About …….. cigarettes/week *or tick :* o0 Can't remember	About …….. cigarettes/week *or tick :* o0 Can't remember	About …….. cigarettes/week *or tick :* o0 Can't remember

48. Have you ever done any vigorous leisure exercise or sports (i.e. exercise that made you breathe faster, such as jogging, swimming, cycling or aerobic exercise)?

o0 No ⟶ ***If No: GO TO QUESTION 49***
o1 Yes

If Yes:

a. In the last 3 months, how often did you do vigorous exercise or sports?

o0 Never
o1 Occasionally *(2-3 times a month)*
o2 Regularly *(about once a week)*
o3 Often *(a few times a week)*
o4 Every day
o5 Can't remember

b. In the last 3 months, did you avoid vigorous exercise at certain times, because of……

	No	**Yes**
Pelvic pain?	o0	o1
Having a period?	o0	o1

c. For ***each*** of the following age groups, please answer approximately how often you did any vigorous exercise, and whether you continued exercise during a period.

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Approximately how often did you do vigorous exercise (e.g. jogging, cycling, swimming, aerobics)?	o0 Never o1 Occasionally *(2-3 times a month)* o2 Regularly *(about once a week)* o3 Often *(a few times a week)* o4 Every day o5 Can't remember	o0 Never o1 Occasionally *(2-3 times a month)* o2 Regularly *(about once a week)* o3 Often *(a few times a week)* o4 Every day o5 Can't remember	o0 Never o1 Occasionally *(2-3 times a month)* o2 Regularly *(about once a week)* o3 Often *(a few times a week)* o4 Every day o5 Can't remember	o0 Never o1 Occasionally *(2-3 times a month)* o2 Regularly *(about once a week)* o3 Often *(a few times a week)* o4 Every day o5 Can't remember	o0 Never o1 Occasionally *(2-3 times a month)* o2 Regularly *(about once a week)* o3 Often *(a few times a week)* o4 Every day o5 Can't remember
Did you usually do the same amount of exercise when you had a period?	o0 Yes (approximately) o1 No, I did less o2 No, I did more o3 Can't remember	o0 Yes (approximately) o1 No, I did less o2 No, I did more o3 Can't remember	o0 Yes (approximately) o1 No, I did less o2 No, I did more o3 Can't remember	o0 Yes (approximately) o1 No, I did less o2 No, I did more o3 Can't remember	o0 Yes (approximately) o1 No, I did less o2 No, I did more o3 Can't remember

49. For ***each*** of the following age groups, how much did you drink of each of the following **during an average week**:

	AGE:				
	up to 20 yrs	**21-25 yrs**	**26-30 yrs**	**31-35 yrs**	**36 yrs and over**
Beer, lager, cider (*please given the equivalent number of half pints*)	… half pints *or tick:* o0 Can't remember	… half pints *or tick:* o0 Can't remember	… half pints *or tick:* o0 Can't remember	… half pints *or tick:* o0 Can't remember	… half pints *or tick:* o0 Can't remember
Wine *(glasses)*?	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember
Sherry/vermouth/port *(glasses)*?	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember	… glasses *or tick:* o0 Can't remember
Spirit/liqueurs *(single measures)*?	… single measures *or tick:* o0 Can't remember	… single measures *or tick:* o0 Can't remember	… single measures *or tick:* o0 Can't remember	… single measures *or tick:* o0 Can't remember	… single measures *or tick:* o0 Can't remember

50. How many siblings do you have? ……sisters and ……brothers

51. Check whether or not any of the following conditions have occurred among your blood relatives.
If a condition has occurred, please tick ✓which relative(s) had the condition.

Condition	**Mother**	**Father**	**Sister**	**Brother**	**Grandparent/ Aunt/Uncle on mother's side**	**Grandparent/ Aunt/Uncle on father's side**
Breast cancer	o0	o1	o2	o3	o4	o5
Colon cancer	o0	o1	o2	o3	o4	o5
Lung cancer	o0	o1	o2	o3	o4	o5
Melanoma	o0	o1	o2	o3	o4	o5
Ovarian cancer	o0	o1	o2	o3	o4	o5
Prostate cancer	o0	o1	o2	o3	o4	o5
Uterine cancer	o0	o1	o2	o3	o4	o5
Asthma	o0	o1	o2	o3	o4	o5
Diabetes	o0	o1	o2	o3	o4	o5

52. Check whether or not any of the following conditions have occurred among blood relatives.
If a condition has occurred, please tick ✓which relative(s) had/have the condition.

Condition	Mother	Sister	Grandmother or Aunt on Mother's side	Grandmother or Aunt on Father's side
Endometriosis	o0	o1	o2	o3
A double or divided uterus	o0	o1	o2	o3
Menopause before aged 46 (not due to hysterectomy)	o0	o1	o2	o3

53. Did your mother smoke cigarettes when she was pregnant with you?

o0 No
o1 Yes
o2 Don't know

If Yes:

a. How frequently did she smoke?

o0 Rarely *(not more than a few cigarettes a month)*
o1 Occasionally *(not more than a few cigarettes a week)*
o2 (Almost) every day
o3 I don't know

PERSONAL INFORMATION

In this final section, we would like to know how your symptoms have impacted on your work and daily activities. We also ask a limited number of non-medical questions regarding your ethnicity, education, and employment. This information will help us to understand how symptoms impact on different groups in the population.

WE REMIND YOU THAT ALL INFORMATION WILL BE TREATED IN COMPLETE CONFIDENCE

54. What is your date of birth? ……. / …….. / ……
(day) (month) (year)

55. How would you describe your ethnic origin?

- o0 American Indian or Alaskan native
- o1 Asian/Oriental
- o2 Black → o0 Black African o1 African American o2 Black Caribbean
- o3 Hispanic or Latino
- o4 Native Hawaiian or other Pacific Islanders
- o5 White → o0 North/West European o1 East European o2 South European o3 North American o4 Other: …….. *(please specify)*
- o6 Mixed Race
- o7 Other: ……. *(please specify)*

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

- o0 Primary
- o1 Lower secondary
- o2 Upper secondary
- o3 Post-secondary not university
- o4 University
- o5 Postgraduate

57. What is your current marital status?

- o0 Single and living with partner
- o1 Married
- o2 Single and not living with partner
- o3 Divorced/separated
- o4 Widowed

→ If one of these: do you have a partner at present?
- o0 No
- o1 Yes

58. What term best describes your current work status?

- o0 Working in a paid job, as an employee → GO TO QUESTION 59
- o1 Self-employed
- o2 Not in paid work force:

Please tick all that apply:

- o0 Housewife / carer
- o2 In education (going to school, university, etc.)
- o3 Doing voluntary work
- o4 Unable to work because of the symptoms for which I am undergoing surgery → GO TO QUESTION 60
- o5 Unable to work for other reasons
- o6 Other: …….. *(please specify)*

59. How many hours a week do you get paid to work? *(if self-employed, specify the number of hours a week that your work on average)*

…… hours

60. Is your planned surgery for tubal sterilisation?

o0 No ⟶ Please go to question **61** if you are either working in a paid job or are self-employed **OR** go to question **65** if you're not in paid work force

o1 Yes ⟶ Go to question 66

The following questions ask about the effect of the **symptoms that led to your scheduled surgery** on your ability to work and perform regular activities **in the past four weeks**.

61. **During the past four weeks**, how many days or hours did you miss from work **because of problems associated with your symptoms**? *Include hours you missed on sick days, times you went in late, left early, etc, because of problems associated with your symptoms. Do not include time you missed to participate in this study*

…….. days or …….. hours

62. During the past four weeks, how many days or hours did you miss from work **because of any other reason**, such as vacation, holidays, time off to participate in this study?

…….. days or …….. hours

63. During the past four weeks, how many days or hours did you actually work?

…….. days or …….. hours *(If '0', skip to question 64.)*

64. During the past four weeks, how much did your **symptoms** affect your productivity **while you were working**?

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If your symptoms affected your work only a little, choose a low number. Choose a high number if your symptoms affected your work a great deal.

You are asked about overall productivity on days you actually went to work. If productivity differed greatly from day to day, for example one day was 0 and one day was 10, please respond for all days, on average.

Consider only how much your **symptoms** affected productivity **while you were working**

Symptoms had no effect on my work — 0 1 2 3 4 5 6 7 8 9 10 — Symptoms completely prevented me from working

65. During the past four weeks, how much did your **symptoms** affect your ability to do your **regular daily activities, other than work at a job?**

*By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If your **symptoms** affected your activities only a little, choose a low number. Choose a high number if you **symptoms** affected your activities a great deal.*

You are asked about overall effect on your activities. If the effect differed greatly from day to day, for example one day was 0 and one day was 10, please respond for all days, on average.

Consider only how much your **symptoms** affected your ability to do your regular activities, **other than work at a job**

Symptoms had no effect on my daily activities — 0 1 2 3 4 5 6 7 8 9 10 — Symptoms completely prevented me from doing my daily activities

66. Please give the date that you completed this questionnaire: ……. / …….. / ……
(day) (month) (year)

67. Please give the date of your planned surgery: ……. / …….. / …… *or tick:* o0 Don't know date yet
(day) (month) (year)

In the future, we may like to contact you to request your participation in much shorter follow-up surveys relating to this study. If you would like to give us the permission to contact you, please fill in your postal address, e-mail address and telephone number where we may contact you in the future. Thank you for participating in this study.

Postal address –
E-mail address –
Telephone number -