Women's Health Symptom Survey

Questionnaire

MEDICAL BACKGROUND

1. What symptom(s) led to your recent gynaecological consultation or 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, I attended for sterilisation	❑0	❑1 →	***If you had no symptoms, please skip to question 2***
Pelvic pain	❑0	❑1	………yr
Pelvic mass	❑0	❑1	………yr
Painful periods	❑0	❑1	………yr
Heavy periods	❑0	❑1	………yr
Infertility	❑0	❑1	………yr
Ovarian cyst	❑0	❑1	………yr
Painful intercourse	❑0	❑1	………yr
Pain on opening bowels	❑0	❑1	………yr
Bleeding from back passage when opening bowels	❑0	❑1	………yr
Bowel upset e.g.: constipation, diarrhoea	❑0	❑1	………yr
Pain on passing urine	❑0	❑1	………yr
Blood in urine	❑0	❑1	………yr
Other urinary problems	❑0	❑1	………yr
Other *(please write:)* …………………………………………….	❑0	❑1	………yr

MENSTRUAL HISTORY AND CONTRACEPTION

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

3. Have you used hormonal contraception (this includes pills, injections, patches, the implant and MIRENA coil) at any time **in the last 3 months**?

❑0 No
❑1 Yes

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

❑0 No **If No:** GO TO QUESTION 6

❑1 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)*

❑0 No
❑1 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 panty liner only)

……. Days ❑0 Too irregular to say

c. How heavy is your menstrual flow usually?

❑$_0$ Light
❑$_1$ Moderate
❑$_2$ Heavy *(clots/flooding)*
❑$_3$ Can't remember

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

❑$_0$ Less than 21 days
❑$_1$ 22-24 days
❑$_2$ 25-28 days
❑$_3$ 29-32 days
❑$_4$33 – 35 days
❑$_5$ More than 36 days
❑$_6$Too irregular to say

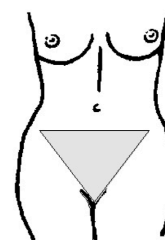
e. Do you have any of the following symptoms when you have a period?

Please tick all that apply

❑$_0$ Pelvic pain (pain in the lower party of your belly)
❑$_1$ Pain on opening your bowels
❑$_2$ Bleeding from your back passage when opening your bowels
❑$_3$ Pain on passing urine
❑$_4$ Passing blood in your urine
❑$_5$ Lower back pain
❑$_6$ Pain in upper leg or thighs
❑$_7$ Nausea
❑$_8$ Tiredness

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:



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

❑$_0$ No → ***If No: Please skip to question 6***
❑$_1$ Yes ↓

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

❑$_0$ Occasionally *(with 1 in 3 of my periods)*
❑$_2$ Often *(with 2 in 3 of my periods)*
❑$_3$ 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?

❑0 No
❑1 Yes

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

❑0 No
❑1 Yes

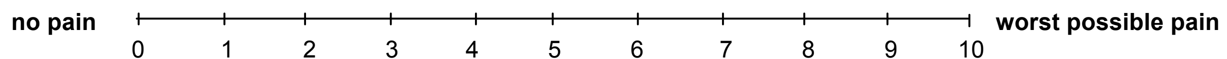
d. In the last 3 months, has your period pain prevented you from going to work or carrying out your daily activities *(even if taking pain-killers)* ?

❑0 Never
❑1 Occasionally *(with 1 in 3 of my periods)*
❑2 Often *(with 2 in 3 of my periods)*
❑3 Always *(with every period)*

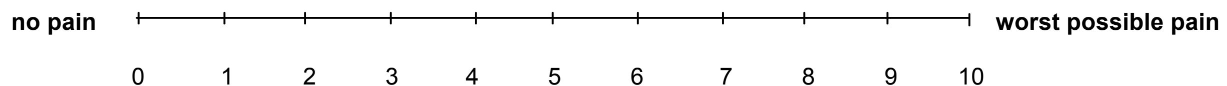
e. In the last 3 months, have you had to lie down for any part of the day or longer because of your period pain?

❑0 Never
❑1 Occasionally *(with 1 in 3 of my periods)*
❑2 Often *(with 2 in 3 of my periods)*
❑3 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?	❑0	❑1	❑2	❑3	❑4
…. how often did you have more frequent bowel movements?	❑0	❑1	❑2	❑3	❑4
…. how often did you have less frequent bowel movements?	❑0	❑1	❑2	❑3	❑4
…. were your stools (bowel movements) *looser*?	❑0	❑1	❑2	❑3	❑4
…. were your stools (bowel movements) *harder* ?	❑0	❑1	❑2	❑3	❑4

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: ❑0 AND GO TO QUESTION 7

IF YOU **HAVE NEVER HAD** SEXUAL INTERCOURSE, PLEASE TICK HERE: ❑0 AND GO TO QUESTION 7

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

❑0 Not applicable: I have not had sexual intercourse in the last 3 months → ***GO TO QUESTION 7***
❑1 No → ***GO TO QUESTION 7***
❑2 Yes ↓

If Yes:

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

❑0 Never
❑1 Occasionally *(less than a quarter of the times)*
❑2 Often *(a quarter to half of the times)*
❑3 Usually *(more than half of the times)*
❑4 Always *(every time)*
❑5 Can't remember

b. Do you ever **interrupt** intercourse because of pelvic pain**?**
❑0 No
❑1 Yes

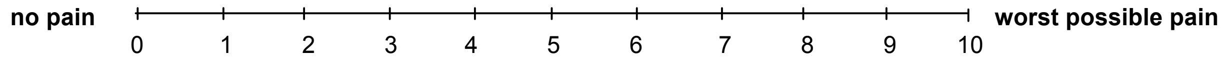
c. Do you ever **avoid** intercourse because of pelvic pain**?**
❑0 No
❑1 Yes

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

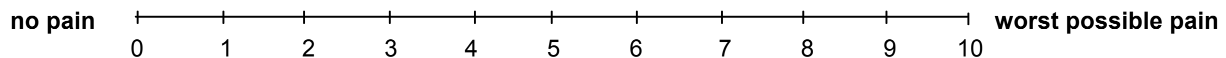
Please tick all that apply

❑0 No
❑1 Yes: during a period
❑2 Yes: just before or after a period
❑3 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**:



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**:



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

❑0 No → ***If No: GO TO QUESTION 8***
❑1 Yes

If Yes:

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

❑0 0 to 3 months ago
❑1 4-6 months ago
❑2 7-12 months ago
❑3 Between 1 and 5 years ago
❑4 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

❑0 No
❑1 Yes, just before a period
❑2 Yes, just after a period
❑3 Yes, at mid-cycle (ovulation)

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

❑0 Less than one day a month
❑1 One day a month
❑3 2-3 days a month
❑4 One day a week
❑5 More than one day a week
❑6 Every day

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

❑0 No
❑1 Yes

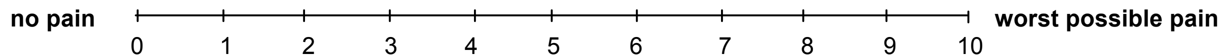
e. Do you take pain-killers for this pain that you can buy without a prescription? *(e.g. Aspirin, Nurofen, Paracetamol)*

❑0 No
❑1 Yes

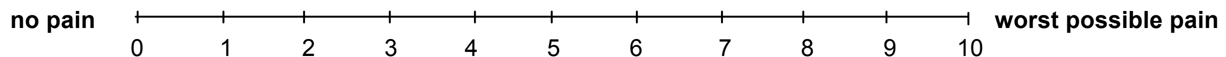
f. Have you ever been admitted to hospital for your pain?

❑0 No
❑1 Yes

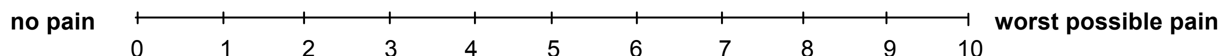
g. Please circle on the following scale, going from no pain (0) to worst possible pain (10), the number that indicates how severe your pain **at times OTHER than with periods or intercourse** has been **ON AVERAGE in the last 3 months**:



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**:



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:**



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?	❑0	❑1	❑2	❑3	❑4
…. how often did you have more frequent bowel movements?	❑0	❑1	❑2	❑3	❑4
…. how often did you have less frequent bowel movements?	❑0	❑1	❑2	❑3	❑4
…. were your stools (bowel movements) *looser*?	❑0	❑1	❑2	❑3	❑4
…. were your stools (bowel movements) *harder* ?	❑0	❑1	❑2	❑3	❑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**
… how often did you have *loose, mushy, or watery* stools?	❑0	❑1	❑2	❑3	❑4
… did you have *hard or lumpy* stools?	❑0	❑1	❑2	❑3	❑4

l. 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?	❑0	❑1	❑2	❑3	❑4	❑5
…. how often have you had to urinate again *less than two hours* after you finished urinating?	❑0	❑1	❑2	❑3	❑4	❑5
…. how often have you found it *difficult to postpone* urination?	❑0	❑1	❑2	❑3	❑4	❑5
…. have you felt *'stinging'* on passing urine?	❑0	❑1	❑2	❑3	❑4	❑5
…. how often have you had *pelvic pain during* urination?	❑0	❑1	❑2	❑3	❑4	❑5
…. how often have you had *pelvic pain after you finished* urination?	❑0	❑1	❑2	❑3	❑4	❑5
…. how often did pelvic pain with urination *increase just before a period*?	❑0	❑1	❑2	❑3	❑4	❑5

…. 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	1 time	2 times	3 times	4 times	5 or more times
	❑0	❑1	❑2	❑3	❑4	❑5

PREGNANCY HISTORY

8. Have you ever been pregnant (including miscarriages, ectopics or terminations)?
(An ectopic pregnancy is a pregnancy outside the womb, most commonly in the tubes)
IF YOU **DO NOT WISH TO ANSWER** THESE QUESTIONS, PLEASE TICK HERE: ❑0 AND SKIP TO QUESTION 9

❑0 No → ***if No: Please skip to question 9***
❑1 Yes

If Yes:
How many pregnancies have you had?

Live births: ….
Still births: ….
Ectopic pregnancies: …
Miscarriages: ….
Terminations (abortions): …..

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

❑0 No → ***If No: Please skip to question 10***
❑1 Yes

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

❑0 No → ***If No: Please skip to question 11***
❑1 Yes

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

❑0 Endometriosis
❑1 Polycystic ovaries
❑2 Pelvic inflammatory disease / Pelvic infection
❑3 Uterine fibroids
❑4 Blocked tubes
❑5 No or irregular ovulation
❑6 Poor sperm count or quality
❑7 Other problem ***(please write):*** ……………………………………………..

MEDICAL HISTORY

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

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

13. What would you say your **natural** hair colour was?

❑$_0$ Fair or Blonde
❑$_1$ Light Brown
❑$_2$ Light Red or Ginger
❑$_3$ Auburn or Dark Red
❑$_4$ Medium Brown
❑$_5$ Dark Brown
❑$_6$ Black

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

	NO	**YES**	**If Yes, first diagnosed at age:**
Asthma	❑$_0$	❑$_1$	……… yrs
Breast Cancer	❑$_0$	❑$_1$	……… yrs
Chronic Fatigue Syndrome (M.E.)	❑$_0$	❑$_1$	……… yrs
Deafness or difficulty hearing	❑$_0$	❑$_1$	……… yrs
Depression requiring medication or medical consultation	❑$_0$	❑$_1$	……… yrs
Diabetes requiring insulin or tablets	❑$_0$	❑$_1$	……… yrs
Eczema	❑$_0$	❑$_1$	……… yrs
Fibroid uterus	❑$_0$	❑$_1$	……… yrs
Fibromyalgia	❑$_0$	❑$_1$	……… yrs
Glandular Fever	❑$_0$	❑$_1$	……… yrs
Hashimoto’s disease	❑$_0$	❑$_1$	……… yrs
Incomplete opening of the vagina (imperforate hymen)	❑$_0$	❑$_1$	……… yrs
Lymphoma – Hodgkin’s	❑$_0$	❑$_1$	……… yrs
Lymphoma – Non-Hodgkin’s	❑$_0$	❑$_1$	……… yrs
Melanoma	❑$_0$	❑$_1$	……… yrs
Migraine	❑$_0$	❑$_1$	……… yrs
Multiple Sclerosis	❑$_0$	❑$_1$	……… yrs
Ovarian Cancer	❑$_0$	❑$_1$	……… yrs
Ovarian Cysts (benign)	❑$_0$	❑$_1$	……… yrs
Polycystic Ovary Syndrome	❑$_0$	❑$_1$	……… yrs
Pyloric Stenosis	❑$_0$	❑$_1$	……… yrs
Rheumatoid Arthritis	❑$_0$	❑$_1$	……… yrs
Scoliosis (curvature of the spine)	❑$_0$	❑$_1$	……… yrs
Other spine problems	❑$_0$	❑$_1$	……… yrs
Sjogren’s syndrome	❑$_0$	❑$_1$	……… yrs
Thyroid disease	❑$_0$	❑$_1$	……… yrs
Mitral valve prolapse	❑$_0$	❑$_1$	……… yrs
SLE (Lupus)	❑$_0$	❑$_1$	……… yrs
Other ***(please specify:)*** …………………………………………………………	❑$_0$	❑$_1$	……… yrs

15. Are you allergic to anything?

❑$_0$ No
❑$_1$ Yes ***(Please specify:)*** ……

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

❑0 No
❑1 Yes
❑2 Don't know

17. 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?

❑0 No moles
❑1 1 to 10 moles
❑2 11 to 50 moles
❑3 More than 50 moles

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

❑0 No ⟶ ***If No: Please skip to question 19***
❑1 Yes

If Yes:

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

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

19. 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)?

❑0 No ⟶ ***If No: GO TO QUESTION 20***
❑1 Yes

If Yes:

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

❑0 Never
❑1 Occasionally *(2-3 times a month)*
❑2 Regularly *(about once a week)*
❑3 Often *(a few times a week)*
❑4 Every day
❑5 Can't remember

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

	No	**Yes**
Pelvic pain?	❑0	❑1
Having a period?	❑0	❑1

PERSONAL INFORMATION AND FAMILY HISTORY

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

21. How would you describe your ethnic origin?
❑0 American Indian or Alaskan Native
❑1 Asian/Oriental
❑2 Black → ❑0 Black African ❑1 African American ❑2 Black Caribbean
❑3 Hispanic/Latin
❑4 Native Hawaiian or other Pacific Islanders
❑5 White → ❑0 North/West European ❑1 East European ❑2 South European
❑3 North American ❑4 Other: ……………………….. *(please specify)*

❑6 Mixed race
❑7 Other……….

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

23. 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	❑0	❑1	❑2	❑3	❑4	❑5
Colon cancer	❑0	❑1	❑2	❑3	❑4	❑5
Lung cancer	❑0	❑1	❑2	❑3	❑4	❑5
Melanoma	❑0	❑1	❑2	❑3	❑4	❑5
Ovarian cancer	❑0	❑1	❑2	❑3	❑4	❑5
Prostate cancer	❑0	❑1	❑2	❑3	❑4	❑5
Uterine cancer	❑0	❑1	❑2	❑3	❑4	❑5
Asthma	❑0	❑1	❑2	❑3	❑4	❑5
Diabetes	❑0	❑1	❑2	❑3	❑4	❑5

24. 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	❑0	❑1	❑2	❑3
A double or divided uterus	❑0	❑1	❑2	❑3
Menopause before aged 46 (not due to hysterectomy)	❑0	❑1	❑2	❑3

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