Attachment 11a

Adult Gynecologic History Form

Gynecological History Questionnaire

INTRODUCTION

This survey includes questions about a number of topics including your menstrual and reproductive history, and other health-related topics.

SECTION A: MENSTRUATION AND MENOPAUSE HISTORY

These questions are about your menstrual periods.

A1. Have you ever had a menstrual period?

☐☐ 1 Yes → **IF YES, GO TO QUESTION A3**

☐☐ 2 No → **IF NO, GO TO QUESTION A2**

A2. Why have you never had a period? Please explain below.

_____

_____

_____

If you answered "no" to question A1 (you never had a menstrual period), please go to Section B on page 6. If you answered "yes" to question A1 (you have had a menstrual period), please continue to question A3.

A3. At what age did you have your first menstrual period?

Age: _____

A4. Did your menstrual periods ever become regular, that is, you could usually predict about when they would start?

☐☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION A7**

A5. At what age did your menstrual periods become regular?

Age: _____

A6. Do you currently have a **regular** menstrual cycle?

☐ 1 Yes

☐☐ 2 No

A7. **How far apart** are your periods now? You may record a single number or a range of days.

Number of days: _____

OR

Range of days: _____ to _____

A8. **How many days of flow** do you usually have during a **typical** menstrual period? You may record a single number or range of days.

Number of days of flow: _____

OR

Range of days: _____ to _____

A9. Did you ever bleed between your periods?

☐☐ 1 Yes

☐☐ 2 No

A10. During any of your periods, have you had excessive bleeding?

☐ ☐ 1 Yes

☐☐ 2 No

A11. Have you ever missed periods for reasons other than pregnancy, breastfeeding, or menopause?

☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION A13**

A12. Why did you miss periods?

_____

_____

_____

A13. On what date did your last or most recent period start?

_____ /_____ /_____
Month Day Year

A14. On what date did the period you had ***before*** your last or most recent period start?

_____ /_____ /_____
Month Day Year

Menopause is when your periods stop for at least one year (NOT because of pregnancy or breastfeeding).

Perimenopause is the time before menopause, when your periods change and become irregular. Your periods also become heavier or lighter before they stop permanently.

Childbearing (or reproductive) years are the years from when you first get your period to perimenopause.

A15. Are you currently menopausal?

☐☐ 1 Yes
☐☐ 2 No → **IF NO, GO TO QUESTION A18**

A16. How old were you when your periods stopped due to menopause?

Age: _____

What year was that? _____
YEAR

A17. Have you had any hot flashes in the past 30 days?

☐☐ 1 Yes
☐☐ 2 No

The next two questions are about your periods during childbearing years.

A18. During the childbearing (reproductive) years of your menstrual cycles, how many days are (were) there **usually** between the beginning of one period and the beginning of the next? You may record a single number or range of days.

Number of days between periods: _____

OR

Range of days: _____ to _____

A19. During the childbearing (reproductive) years of your menstrual cycles, how many days of flow do (did) you usually have during a typical menstrual period? You may record a single number or range of days.

Number of days of flow: _____

OR

Range of days: _____ to _____

SECTION B: PREGNANCY HISTORY

This section of the questionnaire concerns your pregnancy history.

B1. Have you ever been pregnant? (Please include live births, stillbirths, miscarriages, abortions, and tubal and other ectopic pregnancies.)

☐ 1 Yes

☐ 2 No → **IF NO, GO TO SECTION C ON PAGE 11**

B2. How many times have you been pregnant?

Number of pregnancies: _____

B2A. Was your **first** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

☐ 1 Live birth

☐ 2 Stillbirth

☐☐ 3 Miscarriage

☐ 4 Abortion

☐ 5 Ectopic/tubal

☐ 6 Other (Please specify: _____)

If there was a second pregnancy, please continue with B2B. If there was no second pregnancy, go to Box A on Page 9.

B2B. Was your **second** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

☐ 1 Live birth

☐ 2 Stillbirth

☐ 3 Miscarriage

☐ 4 Abortion

☐ 5 Ectopic/tubal

☐ 6 Other (Please specify: _____)

If there was a third pregnancy, please continue with B2C. If there was no third pregnancy, go to Box A on Page 9.

B2C. Was your **third** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was a fourth pregnancy, please continue with B2D. If there was no fourth pregnancy, go to Box A on Page 9.

B2D. Was your **fourth** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was a fifth pregnancy, please continue with B2E. If there was no fifth pregnancy, go to Box A on Page 9.

B2E. Was your **fifth** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was a sixth pregnancy, please continue with B2F. If there was no sixth pregnancy, go to Box A on Page 9.

B2F. Was your **sixth** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was a seventh pregnancy, please continue with B2G. If there was no seventh pregnancy, go to Box A on Page 9.

B2G. Was your **seventh** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was an eighth pregnancy, please continue with B2H. If there was no eighth pregnancy, go to Box A on Page 9.

B2H. Was your **eighth** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was a ninth pregnancy, please continue with B2I. If there was no ninth pregnancy, go to Box A on Page 9.

B2I. Was your **ninth** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

If there was a tenth pregnancy, please continue with B2J. If there was no tenth pregnancy, go to Box A below.

B2J. Was your **tenth** pregnancy a live birth, stillbirth, miscarriage, abortion, or ectopic pregnancy? Please check all that apply.

- ☐ 1 Live birth
- ☐ 2 Stillbirth
- ☐ 3 Miscarriage
- ☐ 4 Abortion
- ☐ 5 Ectopic/tubal
- ☐ 6 Other (Please specify: _____)

B2K. IF YOU HAD MORE THAN 10 PREGNANCIES: Did any of your remaining pregnancies result in live birth?

- ☐ 1 Yes
- ☐ 2 No

BOX A

IF NO PREGNANCY RESULTED IN LIVE BIRTH, PLEASE SKIP TO QUESTION B5.
IF ANY PREGNANCY RESULTED IN LIVE BIRTH, PLEASE GO TO QUESTION B3.

B3. Did you breastfeed any of these babies for two weeks or longer?

- ☐☐ 1 Yes
- ☐ 2 No → **IF NO, GO TO QUESTION B5**

B4. How many babies did you breastfeed for two weeks or longer?

Number of babies breastfed: _____

B5. Have you ever visited a doctor, clinic, or hospital because of difficulty becoming pregnant?

☐ 1 Yes

☐ 2 No

SECTION C: CONTRACEPTIVE AND HORMONE MEDICATION HISTORY

These questions are about your use of contraceptives and hormone medications.

C1. Did you ever use birth control pills, birth control patches, Depo-Provera shots, rings (such as NuvaRing) or the Morning-After pill?

☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION C7**

Please give the names of each contraceptive you have used, the date you started using it, and whether you are still using it. If you are no longer using the contraceptive listed in C1, please record the date you stopped using it and the reason you stopped. If you have a trouble remembering the name of the contraceptive, the nurse at your clinic appointment will have a list that may help you.

	C2. Name of contraceptive	C3. Date started		C4. Are you still using this contraceptive?	C5. IF NO: Date stopped		C6. Why did you stop using this contraceptive?
		Month	Year		Month	Year	
1st				☐ Yes ☐ No			
2nd				☐ Yes ☐ No			
3rd				☐ Yes ☐ No			
4th				☐ Yes ☐ No			
5th				☐ Yes ☐ No			
6th				☐ Yes ☐ No			
7th				☐ Yes ☐ No			

C7. Did you ever take any type of estrogen or hormone medication, such as Premarin, for relief of menopausal symptoms, irregular periods, or prevention of disease such as bone loss?

☐☐ 1 Yes

☐☐ 2 No → **GO TO QUESTION D1 ON PAGE 13**

C8. Were these estrogens or hormones in the form of a…

	YES	NO
a. Pill?	☐ 1	☐ 2
b. Shot?	☐ 1	☐ 2
c. Hormonal vaginal cream or suppository?	☐ 1	☐ 2
d. Patch?	☐ 1	☐ 2

Please give the names of each estrogen or hormone medication you have used, the date you started using it, and whether you are still using it. If you are no longer using the estrogen or hormone medication, please record the date you stopped using it and the reason you stopped. If you have a trouble remembering the name of the estrogen or hormone medication, the nurse at your clinic appointment will have a list that may help you.

	C9. Name of estrogen or hormone medication	C10. Date started		C11. Are you still using this estrogen or hormone medication?	C12. IF NO: Date stopped		C13. Why did you stop using this estrogen or hormone medication?
		Month	Year		Month	Year	
1st				☐ Yes ☐ No			
2nd				☐ Yes ☐ No			
3rd				☐ Yes ☐ No			
4th				☐ Yes ☐ No			
5th				☐ Yes ☐ No			
6th				☐ Yes ☐ No			
7th				☐ Yes ☐ No			

SECTION D. GYNECOLOGICAL DISEASES, CONDITIONS AND SURGERIES

This next section is about certain diseases, conditions, and surgeries you may have had.

D1. Have you ever been diagnosed with a genital infection or a sexually transmitted disease?

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION D3**

D2. For each type of infection or disease listed below, please mark whether you were diagnosed with the infection or disease. If you have been diagnosed with the infection or disease, please write the date you were first diagnosed and any treatment you may have received.

Type of infection or disease	**Were you ever diagnosed with this infection or disease?**	**IF YES: In what month and year were you first diagnosed?**	**IF YES: How was the infection or disease treated?**
D2A. Genital herpes	☐ Yes ☐ No (GO TO D2B)	_____ / _____ MONTH YEAR	
D2B. Bacterial or yeast infection of the vagina (vaginosis)	☐ Yes ☐ No (GO TO D2C)	_____ / _____ MONTH YEAR	
D2C. Inflammation of the uterine tubes ("salpingitis")	☐ Yes ☐ No (GO TO D2D)	_____ / _____ MONTH YEAR	
D2D. Gonorrhea	☐ Yes ☐ No (GO TO D2E)	_____ / _____ MONTH YEAR	
D2E. Chlamydia	☐ Yes ☐ No (GO TO D2F)	_____ / _____ MONTH YEAR	
D2F. Genital warts or HPV (human papilloma virus)	☐ Yes ☐ No (GO TO D2G)	_____ / _____ MONTH YEAR	
D2G. Syphilis	☐ Yes ☐ No (GO TO D2H)	_____ / _____ MONTH YEAR	
D2H. Other disease or infection	Please specify disease or infection: _____ _____	_____ / _____ MONTH YEAR	

Type of infection or disease	Were you ever diagnosed with this infection or disease?	IF YES: In what month and year were you first diagnosed?	IF YES: How was the infection or disease treated?
D2I. Other disease or infection	Please specify disease or infection: _____ _____	_____ / _____ MONTH YEAR	
D2J. Other disease or infection	Please specify disease or infection: _____ _____	_____ / _____ MONTH YEAR	

D3. Have you ever had any surgery or operation involving removal, either partial or total, of one or both of your ovaries, uterus (womb), or tubes? Please include also any surgery to remove cysts from the ovaries, uterus, or tubes.

☐☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION D8**

D4. How many such surgeries or operations have you had?

Number of surgeries or operations: _____

For each surgery, please indicate the month and year of the surgery, what was removed during the surgery, and the reason for the surgery.

	D5. In what month and year did you have the surgery?	D6. What was removed during the surgery?	D7. What was the reason for the surgery?
1.	_____ / _____ MONTH YEAR	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐ ..... One tube ☐☐ ..... Both tubes ☐☐ ..... Cyst (one or more) ☐☐ ..... Other (Please specify: _____)	
2.	_____ / _____ MONTH YEAR	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐ ..... One tube	

	D5. In what month and year did you have the surgery?	D6. What was removed during the surgery?	D7. What was the reason for the surgery?
3.	_____ / _____ MONTH YEAR	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐	
4.	_____ / _____ MONTH YEAR	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐ ..... One tube	
5.	_____ / _____ MONTH YEAR	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐ ..... One tube	

IF YOU HAVE HAD MORE THAN FIVE SURGERIES, PLEASE RECORD THE DATE, TYPE OF SURGERY, AND THE REASON FOR THE SURGERY ON THE BACK OF THIS PAGE.

D8. Have you ever been diagnosed with endometriosis?

☐☐ 1 Yes

☐☐ 2 No → **GO TO QUESTION D11**

D9. In what year were you first diagnosed with endometriosis? If you cannot remember the year, please tell us the age you were first diagnosed.

Year _____

OR

Age _____

D10. How was your endometriosis treated? Please check all that apply.

☐☐ 1 Diagnostic laparoscopy and biopsy
☐☐ 2 Laparoscopy with laser
☐☐ 3 Laparoscopy with excision of ovarian masses
☐☐ 4 Hysterectomy
☐☐ 95 Other (Please specify: _____)
☐ 5 No treatment received
☐ 98 Don't know

D11. Have you ever been diagnosed with polycystic ovarian syndrome (PCOS) or told you had polycystic ovaries?

☐ 1 Yes
☐ 2 No → **IF NO, GO TO QUESTION D14**

D12. In what year were you first diagnosed with polycystic ovarian syndrome (PCOS)? If you cannot remember the year, please tell us your age when you were first diagnosed.

Year _____

OR

Age _____

D13. How were your polycystic ovaries treated? Please check all that apply.

☐☐ 1 Partial resection
☐☐ 2 Laparoscopic drilling
☐☐ 3 Oral contraceptives or hormone therapy
☐☐ 95 Other (Please specify: _____)
☐ 5 No treatment received
☐ 98 Don't know

D14. Have you ever been diagnosed with any other condition affecting the regularity of your periods or your ability to become pregnant?

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION D16**

D15. What diagnosis or diagnoses did you receive? If you cannot remember the name of a diagnosis, please describe your symptoms and treatment.

1.	
2.	
3.	
4.	
5.	

D16. Have you ever been diagnosed with any other gynecological disease or abnormality that you didn't already mention?

☐

☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION D18**

D17. Please describe the other gynecological diseases or abnormalities not mentioned earlier.

_____

_____

_____

_____

_____

D18. In the past 6 months, have you experienced lower abdominal or pelvic pain that is unrelated to your menstrual period?

☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION D24**

D19. Have you had this pain for 6 months or longer?

☐ 1 Yes

☐☐ 2 No

D20. Have you seen a doctor about this lower abdominal or pelvic pain?

☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION D24**

D21. Have you had a diagnostic laparoscopy because of this lower abdominal or pelvic pain?

☐ 1 Yes

☐☐ 2 No → **IF NO, GO TO QUESTION D23**

D22. What was the result of this diagnostic laparoscopy?

_____

_____

_____

_____

D23. Have you had surgery because of this lower abdominal or pelvic pain?

☐ 1 Yes

☐☐ 2 No

D24. Have you had other gynecological surgeries or procedures that you have not yet mentioned in this questionnaire?

☐ 1 Yes → **GO TO QUESTION D25**

☐☐ 2 No → **END OF QUESTIONNAIRE – Thank you!**

D25. For each gynecological surgery or procedure you have had but haven't mentioned yet, please provide the name of the surgery or procedure, the reason for having the surgery or procedure, and your age at the time of the surgery or procedure.

Name of surgery or procedure	**Reason for having surgery or procedure**	**Your age at time of surgery or procedure**

Thank you.

Please bring this questionnaire to your clinic appointment.