Attachment 11b

Adolescent Gynecological History Form

Gynecological History Questionnaire
For Adolescents

INTRODUCTION

This survey includes questions about a number of topics including your menstrual history and other gynecological topics.

SECTION A: MENSTRUATION 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. Do you know why you have never had a period? Please explain below.

_____

_____

_____

BOX A

If you answered "no" to question A1 (you never had a menstrual period), please go to Section B on page 4.
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 → **IF YES, GO TO QUESTION A5**

☐☐ 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. Have you ever had excessive bleeding during your periods?

☐ ☐ 1 Yes

☐☐ 2 No

A11. Have you ever missed a period without being pregnant or breastfeeding?

☐ 1 Yes

☐☐ 2 No

A12. On what day did your last or most recent period start?

_____ /_____ /_____
Month Day Year

A13. On what day did the period you had ***before*** your last or most recent period start?

_____ /_____ /_____
Month Day Year

SECTION B: CONTRACEPTIVE AND HORMONE MEDICATION HISTORY

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

B1. Did you ever use birth control pills, birth control patches, Depo-Provera shots, rings (such as NuvaRing) or the Morning-After pill?

☐ 1 Yes → **IF YES, CONTINUE to B2.**

☐☐ 2 No → **IF NO, GO TO QUESTION B7 ON PAGE 4.**

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 B1, please record the date you stopped using it and the reason you stopped. If you have a trouble remembering the name of the contraceptive, ask a coordinator for a list that may help you.

	B2. Name of contraceptive	B3. Date started		B4. Are you still using this contraceptive?	B5. IF NO: Date stopped		B6. 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			

B7. Did you ever take any type of estrogen or other hormone medication, such as Premarin, for irregular periods?

☐☐ 1 Yes → **IF YES, CONTINUE TO QUESTION B8.**

☐☐ 2 No → **IF NO, GO TO QUESTION C1 ON PAGE 5.**

B8. 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, ask a coordinator for a list that may help you.

	B9. Name of estrogen or hormone medication	B10. Date started		B11. Are you still using this estrogen or hormone medication?	B12. IF NO: Date stopped		B13. 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 C. GYNECOLOGICAL DISEASES, CONDITIONS AND SURGERIES

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

C1. Have you ever been diagnosed with a genital infection or a sexually transmitted disease?

☐☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C2.**

☐☐ 2 No → **IF NO, GO TO QUESTION C3.**

C2. 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?**
C2A. Genital herpes	☐ Yes ☐ No (GO TO C2B)	_____ / _____ MONTH YEAR	
C2B. Bacterial or yeast infection of the vagina (vaginosis)	☐ Yes ☐ No (GO TO C2C)	_____ / _____ MONTH YEAR	
C2C. Inflammation of the uterine tubes ("salpingitis")	☐ Yes ☐ No (GO TO C2D)	_____ / _____ MONTH YEAR	
C2D. Gonorrhea	☐ Yes ☐ No (GO TO C2E)	_____ / _____ MONTH YEAR	
C2E. Chlamydia	☐ Yes ☐ No (GO TO C2F)	_____ / _____ MONTH YEAR	
C2F. Genital warts or HPV (human papilloma virus)	☐ Yes ☐ No (GO TO C2G)	_____ / _____ MONTH YEAR	
C2G. Syphilis	☐ Yes ☐ No (GO TO C2H)	_____ / _____ MONTH YEAR	
C2H. 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?
C2I. Other disease or infection	Please specify disease or infection: _____ _____	_____ / _____ MONTH YEAR	
C2J. Other disease or infection	Please specify disease or infection: _____ _____	_____ / _____ MONTH YEAR	

C3. Have you experienced lower abdominal or pelvic pain that is unrelated to your menstrual period?

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C4.**

☐☐ 2 No → **IF NO, GO TO QUESTION C10.**

C4. Have you had this pain for 6 months or longer?

☐ 1 Yes

☐☐ 2 No

C5. Have you seen a doctor about this lower abdominal or pelvic pain?

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C6.**

☐☐ 2 No → **IF NO, GO TO QUESTION C10.**

C6. What diagnosis and treatment were you given for this lower abdominal or pelvic pain?

Describe:_____

_____

C7. Have you had a diagnostic laparoscopy because of this lower abdominal or pelvic pain?

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C8.**

☐☐ 2 No → **IF NO, GO TO QUESTION C9**

C8. What was the result of this diagnostic laparoscopy?

_____

_____

C9. Have you had surgery because of this lower abdominal or pelvic pain?

☐ 1 Yes

☐☐ 2 No

C10. Have you ever been diagnosed with polycystic ovarian syndrome (PCOS) or told you had polycystic ovaries?

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C11.**

☐ 2 No → **IF NO, GO TO QUESTION C13.**

C11. 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 _____

C12. 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: _____)

☐ 96 No treatment received

☐ 98 Don't know

C13. Have you ever been diagnosed with endometriosis?

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C14.**

☐☐ 2 No → **IF NO, GO TO QUESTION C16.**

C14. 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 _____

C15. 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: _____)
☐ 96 No treatment received
☐ 98 Don't know

C16. Have you ever been diagnosed with any other condition affecting the regularity of your periods or your ability to become pregnant?

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C17.**
☐ 2 No → **IF NO, GO TO QUESTION C18.**

C17. What diagnosis or diagnoses did you receive? If you cannot remember the name of a diagnosis, please describe your symptoms and treatment.

A.	
B.	
C.	
D.	
E.	

C18. Have you ever been diagnosed with any other gynecological disease or abnormality that you didn't already mention?

☐ ☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C19.**
☐☐ 2 No → **IF NO, GO TO QUESTION C20.**

C19. Please describe the other gynecological diseases or abnormalities not mentioned earlier and any treatment you received for them.

_____

_____

_____

_____

_____

C20. 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 any surgery to remove cysts from the ovaries, uterus, or tubes.

☐ 1 Yes → **IF YES, CONTINUE TO QUESTION C21.**

☐☐ 2 No → **IF NO, GO TO QUESTION C25.**

C21. 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.

	C22. In what month and year did you have the surgery?	C23. What was removed during the surgery?	C24. What was the reason for the surgery?
1.	_____ / _____ MONTH YEAR OR Age_____	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 OR Age_____	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐ ..... One tube	

	C22. In what month and year did you have the surgery?	C23. What was removed during the surgery?	C24. What was the reason for the surgery?
3.	_____ / _____ MONTH YEAR OR Age_____	Please check all that apply: ☐☐ ..... One ovary ☐☐ ..... Both ovaries ☐☐ ..... Uterus – partial ☐☐ ..... Uterus – total ☐☐ ..... One tube	

C25. Have you had other gynecological surgeries or procedures that you have not yet mentioned in this questionnaire?

☐ 1 Yes → **IF YES, GO TO QUESTION C26**

☐☐ 2 No → **IF NO, GO TO SECTION D**

C26. 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**

SECTION D: PREGNANCY HISTORY

This section of the questionnaire concerns your pregnancy history.

D1. Have you ever been pregnant? (Please include live births, stillbirths, miscarriages, abortions, and tubal and other ectopic pregnancies.)

☐ 1 Yes → **IF YES, GO TO QUESTION D2**

☐ 2 No → **IF NO, THIS IS THE END OF QUESTIONNAIRE – Thank you!**

D2. How many times have you been pregnant?

Number of pregnancies: _____

D2A. 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 D2B. If there was no second pregnancy, go to Box B on Page 13.

D2B. 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 D2C. If there was no third pregnancy, go to Box B on Page 13.

D2C. 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 D2D. If there was no fourth pregnancy, go to Box B on Page 13.

D2D. IF YOU HAD MORE THAN 3 PREGNANCIES: Did any of your remaining pregnancies result in live birth?

- ☐ 1 Yes
- ☐ 2 No

BOX B

IF NO PREGNANCY RESULTED IN LIVE BIRTH, THIS IS THE END OF QUESTIONNAIRE – Thank you!

IF ANY PREGNANCY RESULTED IN LIVE BIRTH, PLEASE CONTINUE.

D3. Did you breastfeed any baby for two weeks or longer?

☐☐ 1 Yes → **IF YES, CONTINUE TO QUESTION D4**

☐ 2 No → **IF NO, THIS IS THE END OF QUESTIONNAIRE – Thank you!**

D4. How many babies did you breastfeed for two weeks or longer?

Number of babies breastfed: _____

Thank you.

Please bring this questionnaire to your clinic appointment.