RHINESSA WOMEN'S QUESTIONNAIRE

1. What is today's date? (dd/mm/yy) ___/___/___

Menstruation and menstrual related issues

2. How old were you when you had your first period? (years, integers)
   Age (years) _____
   □ Don't know
   □ Never had a period

IF "Never had a period", go to question 12

3. Do you have regular periods? (Tick one box only)

   ☐Yes
   ☐No, they have never been regular
   ☐No, they have been irregular for a few months
   ☐ No, my periods have stopped

   IF "No, my periods stopped":
   3.1. How old were you when they stopped? _____years
   3.2. Did you periods become irregular before they stopped? □ No □ Yes

   IF " YES" (your periods became irregular before they stopped):
   3.2.1.How old were you when they became irregular? _____years

4. What is the usual interval between your periods or what was the usual interval between your periods before they became irregular or stopped? (from the first day of one period to the first day of the next)? (Tick one box only)
   ☐Less than 24 days
   ☐24 - 26 days
   ☐ 27 - 29 days
   ☐ 30 - 32 days
   ☐ 33 - 35 days
   ☐More than 35 days

5. Do you (or did you) usually experience the following symptoms the days before or around your menstrual periods?
   5.1. Anger or irritability? □No □Yes
   5.2. Anxiety or tension? □No □Yes
   5.3. Tearfulness or increased sensitivity to rejections? □No □Yes
   5.4. Feeling depressed or hopeless? □No □Yes
   5.5. Difficulty with sleeping? □No □Yes
   5.6. Abdominal pain (so that you need to take pain killers)? □No □Yes

5.7. Breast tenderness, abdominal bloating and/or swelling? □No □Yes
5.8. Headache? □No □Yes

6. Have you experienced the following symptoms the last three days?
   6.1. Anger or irritability? □No □Yes
   6.2. Anxiety or tension? □No □Yes
   6.3. Tearfulness or increased sensitivity to rejections? □No □Yes
   6.4. Feeling depressed or hopeless? □No □Yes
   6.5. Difficulty with sleeping? □No □Yes
   6.6. Abdominal pain (so that you need to take pain killers)? □No □Yes
   6.7. Breast tenderness, abdominal bloating and/or swelling? □No □Yes
   6.8. Headache? □No □Yes

7. Have menstrual problems ever interfered with your work? □No □Yes

8. Have you ever been off sick due to menstrual problems? □No □Yes

9. Have menstrual problems ever interfered with your home responsibilities? □No □Yes

10. When was your last period?
    Please fill in the date of the first day of your last period: (dd/mm/yy)
    (or the year, if you cannot remember the exact date,even if you are no longer menstruating)" ___dd ____mm _____yy

11. How many periods have you had in the last 12 months? ___ periods

    11.1. If you had periods in the last 12 months
        11.1.1. Is your menstrual cycle often (more than twice a year) more than 35 days? □No □Yes
        11.1.2. Have your periods been irregular over the last 12 months? □No □Yes
            11.1.2.1. If **YES**: For how long have your periods been irregular? _____months
    11.2. If you have had no periods in the last 12 months:
        11.2.1. What statement best describes the reason you have not had a period in the last 12 months? (Tick one box only)
            ☐Menopause
            ☐Hysterectomy (womb removed)
            ☐Ovaries removed
            ☐Currently Pregnant
            ☐Currently Breast feeding
            ☐Because I have been taking treatments (eg hormonal IUD, contraceptive implants, chemotherapy)
            ☐Other, please describe:_____
            _____

12. Are you currently pregnant? □ No □Yes

If YES ;
12.1. What is the lenght of the pregnancy now? _____weeks

13. Are you currently breast-feeding? □No □Yes

Gynaecological problems

14. Have you ever had a hysterectomy (your womb removed)? □No □Yes

If YES:
14.1. How old were you when you had a hysterectomy? _____years

14.2. What was the main reason for the hysterectomy? (Tick one box only)
- ☐Heavy or painful or irregular periods
- ☐Fibroids, (with or without heavy, painful or irregular periods)
- ☐Cancer of the womb (endometrium)
- ☐Cancer of the ovary
- ☐Cancer of the cervix
- ☐Vaginal prolapse
- ☐Don't know/don't wish to say
- ☐Other, please describe:_____

15. Have you ever had one or both ovaries removed? (Tick one box only)
- ☐Never
- ☐Yes, one ovary
- ☐Yes, two ovaries
- ☐Don't know

If YES, you have had one or both ovaries removed:
15.1. How old were you when you had your ovary/ies removed? Please fill out two boxes if the ovaries were removed at different ages. _____years _____years

16. Have you ever had excessive growth of body hair? □No □Yes

17. Has a doctor or health professional ever told you that you have:
17.1. Ovarian cyst or cysts? □No □Yes
If YES: How old were you when a doctor told you that you had ovarian cyst/s? _____years

17.2. Polycystic ovaries or polycystic ovarian syndrome (PCOS)? □No □Yes
If YES: How old were you when a doctor told you that you had polycystic ovaries or polycystic ovarian syndrome (PCOS)? _____years

17.3. Fibroids? □No □Yes
If YES: How old were you when a doctor told you that you had fibroids? _____years

17.4. Endometriosis? □No □Yes
If YES: How old were you when a doctor told you that you had endometriosis? _____years

18. Has a doctor or health professional ever treated you for:
18.1. Eating disorders (anorexia, bulimia)? □No □Yes
If YES: How old were you when you were first treated for eating disorder? _____years

18.2. Acne? □No □Yes
If YES: How old were you when you were first treated for acne? _____years

18.3. Infertility? □No □Yes
If YES: How old were you when you were first treated for infertility? _____years

Hormonal treatments

19. Are you currently taking any hormonal treatments? □No □Yes

If "NO", go to question 20; if "YES":
19.1. For contraception (eg 'the pill') □No □Yes
19.2. Treatment of menopausal symptoms (eg HRT) □No □Yes
19.3. Treatment to help you get pregnant □No □Yes
19.4. Treatment for gynaecological disorders □No □Yes
19.5. Other treatment □No □Yes

20. Have you **ever** taken hormonal contraceptives (eg the pill, patches, injections, implants, coil impregnated with hormone eg. Mirena)? □No □Yes

If NO, go to question 21; If YES:
20.1. How old were you when you first took hormonal contraceptives? _____years

20.2. Were your periods irregular before you started taking hormonal contraceptives? □No □Yes
20.3. Which of the following reasons were the main reasons for taking the hormonal contraceptives (eg: the pill, hormonal coil)? (Tick as many boxes as apply)
☐Contraception
☐Irregular periods
☐Painful periods
☐Heavy menstrual bleeding
☐Polycystic ovarian syndrome
☐Acne

☐Endometriosis

20.4. How old were you when you last took hormonal contraceptives?
(If you currently take hormonal contraceptives please give your current age) _____ years

20.5. How long in total have you/did you take the following types of hormonal contraceptives?
(If you have taken them on and off for some time intervals please provide an estimate of the total number of years taken)

☐ Tablets _____years
☐ Patches _____years
☐ Vaginal ring _____years
☐ Injections/implants _____years
☐ Coil impregnated with hormones _____years

Pregnancies

21. What statement best describes your current situation regarding pregnancy? (Tick one box only)

☐ I have never tried to get pregnant
☐ I have been pregnant one or more times naturally
☐ I have only been pregnant following fertility treatment
☐ I have never been pregnant, and I have been told that I have a medical problem that prevents me from getting pregnant
☐ I have never been pregnant, and I have been advised that I have a medical problem that would make it dangerous for me to get pregnant
☐ None of the above
☐ I do not wish to answer

22. Have you ever had a miscarriage
(involuntary interruption of pregnancy before week 24)? □ No □ Yes

22.1. *If YES:* How many miscarriages have you had? _____

23. Have you ever had a baby (including still-born babies after week 24 in pregnacy)? □ No □ Yes

If NO go to question 24

23.1. *If YES*: How many children have you had? _____children

23.2. For each child you have given birth to, please answer the following questions, starting with the oldest one

	First child	23.2.1	Second child	23.2.2	Third child	23.2.3
of birth (yyyy)		23.2.1.1		23.2.2.1		23.2.3.1
ler (enter boy or girl)	☐ boy ☐ girl	23.2.1.2	☐ boy ☐ girl	23.2.2.2	☐ boy ☐ girl	23.2.3.2
weight in kg, to one decimal point, ex 3.5 kg)	,	23.2.1.3	,	23.2.2.3	,	23.2.3.3
this child born (tick one box, for each child):		23.2.1.4		23.2.2.4		23.2.3.4
er than 32 weeks	☐		☐		☐	
36 weeks	☐		☐		☐	
42 weeks	☐		☐		☐	
than 42 weeks	☐		☐		☐	
weight gain in the pregnancy (kg) (approximately)		23.2.1.5		23.2.2.5		23.2.3.5
ng this pregnancy (tick if yes):						
e you hospitalised with nausea and vomiting (hyperemesis)?	☐	23.2.1.6.1	☐	23.2.2.6.1	☐	23.2.3.6.1
you have high blood pressure and/or protein in your urine?	☐	23.2.1.6.2	☐	23.2.2.6.2	☐	23.2.3.6.2
you have sugar in your urine (glycosuria)?	☐	23.2.1.6.3	☐	23.2.2.6.3	☐	23.2.3.6.3
you develop diabetes?	☐	23.2.1.6.4	☐	23.2.2.6.4	☐	23.2.3.6.4
you smoke?	☐	23.2.1.6.5	☐	23.2.2.6.5	☐	23.2.3.6.5
the labour induced? (tick if yes)	☐	23.2.1.7	☐	23.2.2.7	☐	23.2.3.7
the baby born:		23.2.1.8		23.2.2.8		23.2.3.8
raly	☐		☐		☐	
forceps	☐		☐		☐	
ventouse or vacuum	☐		☐		☐	
arean section	☐		☐		☐	
you breastfeed for three months or more? (tick if yes)	☐	23.2.1.9	☐	23.2.2.9	☐	23.2.3.9

23.2 Continue filling in the form if you have given birth to more than 3 children

	Fourth child	23.2.4	**Fifth child**	23.2.5	**Sixth child**	23.2.6
Year of birth (yyyy)		23.2.4.1		23.2.5.1		23.2.6.1
Gender (enter boy or girl)	☐ boy ☐ girl	23.2.4.2	☐ boy ☐ girl	23.2.5.2	☐ boy ☐ girl	23.2.6.2
Birth weight in kg, to one decimal point, ex 3.5 kg)	,	23.2.4.3	,	23.2.5.3	,	23.2.6.3
Was this child born (tick one box, for each child):		23.2.4.4		23.2.5.4		23.2.6.4
Earlier than 32 weeks	☐		☐		☐	
32 to 36 weeks	☐		☐		☐	
37 to 42 weeks	☐		☐		☐	
Later than 42 weeks	☐		☐		☐	
Your weight gain in the pregnancy (kg) (approximately)		23.2.4.5		23.2.5.5		23.2.6.5
During this pregnancy (tick if yes):						
Were you hospitalised with nausea and vomiting (hyperemesis)?	☐	23.2.4.6.1	☐	23.2.5.6.1	☐	23.2.6.6.1
Did you have high blood pressure and/or protein in your urine?	☐	23.2.4.6.2	☐	23.2.5.6.2	☐	23.2.6.6.2
Did you have sugar in your urine (glycosuria)?	☐	23.2.4.6.3	☐	23.2.5.6.3	☐	23.2.6.6.3
Did you develop diabetes?	☐	23.2.4.6.4	☐	23.2.5.6.4	☐	23.2.6.6.4
Did you smoke?	☐	23.2.4.6.5	☐	23.2.5.6.5	☐	23.2.6.6.5
Was the labour induced? (tick if yes)	☐	23.2.4.7	☐	23.2.5.7	☐	23.2.6.7
Was the baby born:		23.2.4.8		23.2.5.8		23.2.6.8
Naturaly	☐		☐		☐	
With forceps	☐		☐		☐	
With ventouse or vacuum	☐		☐		☐	
Caesarean section	☐		☐		☐	
Did you breastfeed for three months or more? (tick if yes)	☐	23.2.4.9	☐	23.2.5.9	☐	23.2.6.9

Menopause

24. "Some women experience hot flushes, flashes and/or night sweats around the time of the menopause, even when they are having menstrual cycles.Have you ever had either of these symptoms at a time which could berelated to the menopause?" □ No □ Yes

If "NO", end to Questionnaire; If YES:

24.1. How old were you when these symptoms started? _____years

24.2. "How old were you when you last experienced these symptoms? (If you currently have these symptoms please give your current age)" _____years

24.3. "How often have you had hot flushes/night sweats in the past 6 months? (Tick one box only)"

☐ Never
☐ Less than once a week
☐ More than once a week, but not every day
☐ Every day

25. Have you ever taken hormonal treatment for the menopause (tablets, cream, patches, vaginal creams or vaginal pessaries? □ No □ Yes

If "NO", end to Questionnaire; If YES:

25.1. How old were you when you first took hormonal treatments for the menopause? _____years

25.2. At the time you started taking hormonal treatment for the menopause, how often were your periods? (Tick one boxe only)

☐ I had not had period in the previous 12 months
☐ I had at least one period in the previous 12 months, but my cycles had become irregular
☐ My periods were regular during the previous 12 months

25.3. At the time you started this medication, were you experiencing hot flushes/flashes/night sweats? □ No □ Yes