

Entered: __/__/20__ mm dd yy	Initials: _____	Verified: __/__/20__ mm dd yy	Initials: _____
Patient ID _____ - _____ - _____ ID			VISIT Visit: _____
For office use only.			

RHF –Version 01/01/2010 FORMV

Form Completion Date __/__/20__ **RHF DAT**
mm dd yy

The following set of questions is for females only.

1. Has a healthcare professional ever told you that you have/had polycystic ovary syndrome (PCOS)?

PCOS

0. No 1. Yes

↓
*Go to
question 2*

1.1 How are you currently treating your PCOS? (Check “no” or “yes” to each item.)

No	Yes	No	Yes
<input type="checkbox"/>	<input type="checkbox"/> No treatment PCOSNOT	<input type="checkbox"/>	<input type="checkbox"/> Exercise PCOSEXER
<input type="checkbox"/>	<input type="checkbox"/> Diet PSOSDIET	<input type="checkbox"/>	<input type="checkbox"/> Prescription medication PCOSMED

2. In the **past 12 months** have you taken any hormonal medication, such as hormone replacement therapy (HRT), the pill, or fertility medication? **HORM**

0. No 1. Yes

↓
*Go to
question 3*

2.1 Please indicate which type of hormonal medication you have taken in the **past 12 months**:
HORMTYPE

1. Hormone replacement therapy → *Skip to question 7, next page*

2. Hormonal birth control (such as pill, ring, shot, Mirena) → *Skip to question 9, next page*

3. Fertility medication → *Skip to question 9, next page*

Thinking back over the **past 12 months...**

3. In how many of those months did you have a period?

PERIOD

_____ *If zero, please skip to question 7, next page*

4. What was the usual length of your menstrual cycle (interval from the first day of period to the first day of next period)?

MCYCLE

1. Less than 21 days 2. 21 – 35 days 3. More than 35 days 4. Too irregular to estimate

5. On average, how many days did your period (bleeding) last? **PLAST**

1. 1 – 4 days 2. 5 – 7 days 3. 8 – 9 days 4. More than 9 days

6. Did you have spotting or bleeding that occurred at times other than your menstrual period? **SPOT**

0. No 1. Yes

↓
*Skip to
question 9*

6.1 In how many of the **past 12 months** did this occur? **_SPOTS_** (months) → *Skip to question 9*

7. Please indicate how bothersome the following symptoms have been in the past month:

	Not at all (1)	Slightly (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
7.1 Hot flashes or flushes HFLASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.2 Sleep disturbance (difficulty falling or staying asleep or early waking) SLEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.3 Vaginal dryness VAGDRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Why did your natural menstrual period stop (*check only one response*)? **MENSSTOP**

- 2** Natural menopause
- 10** Hysterectomy alone (*uterus removed, not both ovaries removed*)
- 11** Hysterectomy and oophorectomy (*uterus and both ovaries removed*)
- 12** Oophorectomy alone (*both ovaries removed; uterus not removed*)
- 13** Endometrial ablation (*lining of uterus destroyed, uterus not removed*)
- 1** Medication
- 4** Chemotherapy
- 5** Chronic illness
- 6** Prolactin, adrenal gland or thyroid problem
- 7** Pregnancy
- 14** Breast feeding
- 8** No known reason
- 9** Other (Specify: _____ **MENSTOPS** _____)

Do not answer the remainder of this survey

9. Are you 50 years old or older? 0. No 1. Yes → *if yes, please do not answer the remainder of this survey. If you are 49 or younger, please continue.*
FIFTY

10. In the **past 12 months** have you regularly been having sexual intercourse with a man and not used any form of birth control and yet you did not become pregnant? **NOPREG12**

- 0. No
- 1. Yes

11. In the **past 12 months** how often have you used birth control when having sexual intercourse with a man? **BCNTLS**

- 0. Not sexually active with a man
- 1. Never
- 2. Rarely
- 3. About half the time
- 4. Most of the time
- 5. All of the time

BCNTL

12. In the **past 12 months** have you (or has your partner) used birth control for any reason? 0. No 1. Yes

12.1 Specify birth control you have used in the past 12 months (Check "no" or "yes" for each item).			
No (0)	Yes (1)	No (0)	Yes (1)
<input type="checkbox"/>	<input type="checkbox"/> Pills, monthly (including one week of placebo or no pills, get period) PILLSM	<input type="checkbox"/>	<input type="checkbox"/> Diaphragm DIAPH
<input type="checkbox"/>	<input type="checkbox"/> Pills, continuous use (new pack every 3 weeks, no period) PILLSC	<input type="checkbox"/>	<input type="checkbox"/> Cervical cap CAP
<input type="checkbox"/>	<input type="checkbox"/> Mini Pill, continuous use (progestin only, get period) MINIPILL	<input type="checkbox"/>	<input type="checkbox"/> Male or female condom CONDOM
<input type="checkbox"/>	<input type="checkbox"/> Patch or ring RING	<input type="checkbox"/>	<input type="checkbox"/> Contraceptive foams, creams, jellies FOAMS
<input type="checkbox"/>	<input type="checkbox"/> Injections of medications (shots) or implanatation of a medications release device SHOTS	<input type="checkbox"/>	<input type="checkbox"/> Natural family planning, rhythm method or having sex during "safe" times NATURAL
<input type="checkbox"/>	<input type="checkbox"/> IUD IUD → <input type="checkbox"/> Mirena <input type="checkbox"/> Copper <input type="checkbox"/> Don't know IUDTYPE	<input type="checkbox"/>	<input type="checkbox"/> Withdrawal WITHD
		<input type="checkbox"/>	<input type="checkbox"/> Tubal ligation: your tubes were tied TUBAL
		<input type="checkbox"/>	<input type="checkbox"/> Vasectomy: your partner was sterilized VASECT
		<input type="checkbox"/>	<input type="checkbox"/> Other BCNTLO (Specify: _____ BCNTLOS _____)

13. Have you tried to become pregnant in the **past 12 months**? **PREG12**

- 0. No → *Skip to question 16*
- 1. Yes

14. In the **past 12 months** have you talked to a doctor or had tests done because of problems becoming pregnant? **PRGPRB12**

- 0. No → *Skip to question 16*
- 1. Yes

15. In the **past 12 months** have you taken any fertility medication to help you become pregnant (such as Clomid, Serophene, Gonal-F, Follistim)? **FERT12**

- 0. No → *Go to question 16*
- 1. Yes

16. Since your **bariatric surgery** how many times have you been pregnant? # _____ *If zero, please do not answer the **PRGNUMBS** remainder of this survey.*

17. Are you **currently** pregnant? **PREGCUR**

0. No → *skip to Q18*

1. Yes



PREGCM / PREGCD / PREGCY

17.1 Due date ___ / ___ / 20 ___ (If you do not know exact date, complete month and year)
mm dd yy

17.2 Were you on fertility treatment when you became pregnant? **PREGCFT**

0. No

1. Yes

18. In the **past 12 months**, have you had any pregnancies **end** (due to miscarriage, ectopic or tubal pregnancy, abortion, still birth or live birth)? **PREGEND**

0. No → *Thank you. You have completed the survey packet.*

1. Yes → *Please continue.*

19. How many pregnancies have **ended** in the **past 12 months**: # _____ **PREGENDN**

Please continue to the next page to complete a pregnancy questionnaire for each pregnancy that has ended in the past 12 months. If you do not have enough pregnancy questionnaires, please ask the research staff for more. Thank you!