ECRHS III – WOMENS QUESTIONNAIRE – FOR NOVEMBER TRAINING

ALL ABOUT WOMEN

1. What is today's date?

Day			Month			Year	

2. How old were you when you had your first period?

Years	

(*if you have never had a period please enter 88 and go to question 8*)

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	

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 from the following symptoms the days before or around your menstrual periods?

		No	Yes
5.1	Anger/irritability		
5.2	Anxiety or tension		
5.3	Tearfulness or increased sensitivity to rejections		
5.4	Feeling depressed or hopeless		
5.5	Difficulty with sleeping		
5.6	Abdominal pain (so that you needed to take pain killers)		

6. When was your last period?

Day			Month			Year	

(Please fill in the date of the first day of your last period, or the year, if you cannot remember the exact date, even if you are not longer menstruating)

7. How many periods have you had in the last 12 months? Number ☐☐

7.1 If you had periods in the last 12 months

7.1.1 Is your menstrual cycle often (more than twice a year) more than 35 days? No ☐ Yes ☐

7.1.2 Have your periods been irregular over the last 12 months? No ☐ Yes ☐

If your periods have been irregular over the last 12 months
7.1.2.1 For how long have your periods been irregular? Months ☐☐

7.1.3 Are you currently pregnant? No ☐ Yes ☐
7.1.4 Are you currently breast feeding? No ☐ Yes ☐

7.2 If you had no period in the last 12 months

7.2.1 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_____ ☐

7.2.2. Did your periods become irregular before they stopped? No ☐ Yes ☐

If your periods became irregular before they stopped
7.2.2.1 How old were you when they became irregular? Years ☐☐

FOR ALL WOMEN (CONTINUED)

8. Have you ever had a hysterectomy (your womb removed)? No ☐ Yes ☐

If you have had a hysterectomy –
8.1 How old were you when you had a hysterectomy? Years ☐☐

8.2 What was the **main** reason you had a 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…… ☐

FOR ALL WOMEN (CONTINUED)

9. Have you ever had one or both ovaries removed?

Tick one box only

- Never ☐
- Yes, one ovary ☐
- Yes, two ovaries ☐
- Don't know ☐

If you have had one or both ovaries removed –

9.1 How old were you when you had your ovary/ies removed? Years ☐☐
(Fill-in 2 lines if you had your 2 ovaries removed at a different age) ☐☐

10. Have you ever had excessive growth of body hair? No ☐ Yes ☐

11. Has a doctor or health professional ever told you have….

	No	Yes		Years
11.1 Ovarian cyst or cysts	☐	☐	**11.1.1** How old were you when a doctor told you you had ovarian cyst/s?	☐☐
11.2 Polycystic ovaries or polycystic ovarian syndrome (PCOS)	☐	☐	**11.2.1** How old were you when a doctor told you you had polycystic ovaries or polycystic ovarian syndrome (PCOS) ?	☐☐
11.3 Fibroids	☐	☐	**11.3.1** How old were you when a doctor told you you had fibroids?	☐☐
11.4 Endometriosis	☐	☐	**11.4.1** How old were you when a doctor told you you had endometriois?	☐☐
11.5 Osteoporosis	☐	☐	**11.5.1** How old were you when a doctor told you you had osteoporosis?	☐☐

12. Has a doctor or health professional ever treated you for

	No	Yes		Years
12.1 Eating disorders (anorexia, bulimia)	☐	☐	**12.1.1** How old were you when you were first treated for eating disorder?	☐☐
12.2 Acne	☐	☐	**12.2.1** How old were you when you were first treated for acne?	☐☐
12.3 Infertility	☐	☐	**12.3.1** How old were you when you were first treated for infertility?	☐☐
12.4 Vaginal prolapse	☐	☐	**12.4.1** How old were you when you were first treated for vaginal prolapse?	☐☐

13. Some women experience hot flushes (or flashes)/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 be related to the menopause? No ☐ Yes ☐

If yes – 13.1 How old were you when these symptoms started? Years ☐☐

13.2 How old were you when you last experienced these symptoms? *(If you currently have these symptoms please give your current age)* Years ☐☐

13.3 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 ☐

FOR ALL WOMEN (CONTINUED)

14. Are you currently taking any hormonal treatments

		No		Yes
14.1	**for contraception (eg 'the pill')**			
14.2	**treatment of menopausal symptoms (eg HRT)**			
14.3	**treatment to help you get pregnant**			
14.4	**to treat gynaecological disorders, or other treatment**			

If you are currently taking hormonal treatments – please describe below
Please write as clearly as possible

Reason taken		Name of treatment you are currently taking		Type of medication eg: tablet, patch, injection, implant, hormonal coil (IUD)		Number of months using this treatment	
Contraception	14.1.1		14.1.2		14.1.3		
Menopause	14.2.1		14.2.3		14.2.5		
	14.2.2		14.2.4		14.2.6		
Infertility	14.3.1		14.3.3		14.3.5		
	14.3.2		14.3.4		14.3.6		
Other	14.4.1		14.3.2		14.3.7		

(for treatment for menopause, or for infertility, fill-in 2 lines if you are currently using 2 treatments)

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

If yes

15.1 How old were you when you first took hormonal contraceptives? Years

15.2 Were your periods irregular before you started taking hormonal contraceptives? No / Yes

15.3 Which of the following reasons were the main reasons for taking the hormonal contraceptives (eg: the pill, hormonal coil)?

		No	Yes
15.3.1	Contraception		
15.3.2	Irregular periods		
15.3.3	Painful periods		
15.3.4	Heavy menstrual bleeding		
15.3.5	Polycystic ovarian syndrome		
15.3.6	Acne		
15.3.7	Endometriosis		

15.4 How old were you when you last took hormonal contraceptives? Years
(If you currently take hormonal contraceptives please give your current age)

15.5 How long in total have you/did you take the following types of hormonal contraceptives?

	Years
Tablets	
Patches	
Vaginal ring	
Injections/implants	
Coil impregnated with hormones	

(If you have taken them on and off for some time intervals please provide an estimate of the total number of years taken)

FOR ALL WOMEN (CONTINUED)

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

If yes

16.1 How old were you when you first took hormonal treatments for the menopause? Years

16.2 At the time you started taking hormonal treatment for the menopause, how often were your periods? Tick one box only

- I had not had period in the 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

16.3 At the time you started this medication were you experiencing hot flushes/night sweats? No / Yes

16.4 How old were you when you last took hormonal treatments for the menopause *(If you currently take hormonal treatments for menopause please give your current age)* Years

16.5 How long in total have you/did you take the following types of hormonal treatments for the menopause? Years

- Oral preparations
- Patches
- Vaginal preparations

(If you have taken them on and off for some time intervals please provide an estimate of the total number of years taken)

16.6 For each years of age between age 40 and now, please tick the years when you take the following types of hormonal treatments for the menopause.
If you have taken then off and again, please tick the years when you used them, leave blanks for years when you did not use them, and tick again the years when you used them again.
If you used several treatments at the same age, tick them all in the same age column

age	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
Oral preparations																										
Patches																										
Vaginal preparations																										

17. Have you ever used DHEA (dehydroepiandosterone)? No / Yes

If yes

17.1 How old were you when you first took DHEA? Years

17.2 How old were you when you last took DHEA? Years

(If you currently take DHEA please give your current age)

FOR ALL WOMEN (CONTINUED)

18. What statement best describes your current situation regarding pregnancy?

Tick one box only

I have never tried to get pregnant	1
I have been pregnant one or more times naturally	2
I have only been pregnant following fertility treatment	3
I have never been pregnant and I have been told that I have a medical problems that prevents me from getting pregnant	4
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	5
None of the above	6
I do not wish to say	7

19. Have you ever had a miscarriage? No | Yes | Don't wish to answer

If yes

19.1 How many miscarriages have you had?

20. Have you ever had a baby (including still-born babies, if any)? No | Yes | Don't wish to answer

If yes

20.1 How many babies have you had?

20.2 FOR ALL WOMEN WHO HAVE HAD A BABY

For each child you have, please can you answer the following questions,starting with the first born. If you have more than 6 children, please refer to the 6 younger children.

Child Number 1

20.2.1.1 Year of birth

20.2.1.2 Gender — Boy / Girl

20.2.1.3 Birthweight — KILOS • | **OR** POUNDS | **AND** OUNCES

To all fieldworkers –please convert into kilos for data entry

20.2.1.4 Was this child born — TICK ONE BOX ONLY

Before 32 weeks	
After 32 weeks but before 37 weeks	
On time (37-42 weeks)	
After 42 weeks	

Child Number 2

20.2.2.1 Year of birth [ ][ ][ ][ ]

20.2.2.2 Gender Boy [ ] Girl [ ]

20.2.2.3 Birthweight KILOS [ ] • [ ][ ][ ] **OR** POUNDS [ ][ ] **AND** OUNCES [ ][ ]

20.2.2.4 Was this child born (TICK ONE BOX ONLY)

- Before 32 weeks [ ]
- After 32 weeks but before 37 weeks [ ]
- On time (37-42 weeks) [ ]
- After 42 weeks [ ]

Child Number 3

20.2.3.1 Year of birth [ ][ ][ ][ ]

20.2.3.2 Gender Boy [ ] Girl [ ]

20.2.3.3 Birthweight KILOS [ ] • [ ][ ][ ] **OR** POUNDS [ ][ ] **AND** OUNCES [ ][ ]

20.2.3.4 Was this child born (TICK ONE BOX ONLY)

- Before 32 weeks [ ]
- After 32 weeks but before 37 weeks [ ]
- On time (37-42 weeks) [ ]
- After 42 weeks [ ]

Child Number 4

20.2.4.1 Year of birth [ ][ ][ ][ ]

20.2.4.2 Gender Boy [ ] Girl [ ]

20.2.4.3 Birthweight KILOS [ ] • [ ][ ][ ] **OR** POUNDS [ ][ ] **AND** OUNCES [ ][ ]

20.2.4.4 Was this child born (TICK ONE BOX ONLY)

- Before 32 weeks [ ]
- After 32 weeks but before 37 weeks [ ]
- On time (37-42 weeks) [ ]
- After 42 weeks [ ]

Child Number 5

20.2.5.1 Year of birth ☐☐☐☐

20.2.5.2 Gender Boy ☐ Girl ☐

20.2.5.3 Birthweight KILOS ☐ • ☐☐☐ **OR** POUNDS ☐☐ **AND** OUNCES ☐☐

20.2.5.4 Was this child born (TICK ONE BOX ONLY)

- Before 32 weeks ☐
- After 32 weeks but before 37 weeks ☐
- On time (37-42 weeks) ☐
- After 42 weeks ☐

Child Number 6

20.2.6.1 Year of birth ☐☐☐☐

20.2.6.2 Gender Boy ☐ Girl ☐

20.2.6.3 Birthweight KILOS ☐ • ☐☐☐ **OR** POUNDS ☐☐ **AND** OUNCES ☐☐

20.2.6.4 Was this child born (TICK ONE BOX ONLY)

- Before 32 weeks ☐
- After 32 weeks but before 37 weeks ☐
- On time (37-42 weeks) ☐
- After 42 weeks ☐

FOR ALL WOMEN (CONTINUED)

21. How often do you usually use the following personal products?

Tick one box per product		Never	<1 day/ week	1-3 days/ week	4-7 days/ week	>1 time/ day
21.1	Perfume spray	☐	☐	☐	☐	☐
21.2	Perfume (not spray)	☐	☐	☐	☐	☐
21.3	Deodorant spray	☐	☐	☐	☐	☐
21.4	Deodorant stick	☐	☐	☐	☐	☐
21.5	Hair spray	☐	☐	☐	☐	☐
21.6	Moisturising cream	☐	☐	☐	☐	☐
21.7	Lotions	☐	☐	☐	☐	☐
21.8	Cleansing cream	☐	☐	☐	☐	☐
21.9	Nail polishes	☐	☐	☐	☐	☐
21.10	Nail polishes remover	☐	☐	☐	☐	☐
	code	1	2	3	4	5