LOGO
FIELD ORGANIZATION

ZEG Berlin

INAS-VIPOS

– Follow-up Questionnaire No. [N] –

Country | Physician no. | Patient no. | ID

If you have any questions, please call our free phone number: [telephone number]

Endometriosis Treatment

1. Have you used any hormonal treatment for your endometriosis since we last heard from you in [month/year]?[1]

☐ Yes → *Please fill in all medications with dates and reasons for stopping / switching you have used since [month/year] in the table below*

Brand name of medication [2]	From	To	Reasons for switching or stopping (Please tick appropriate box) [8]
	MM month [3] YYYY year [4]	MM month [5] YYYY year [6] ☐ ongoing[7]	☐ Trying to become pregnant ☐ Treatment duration finished ☐ Medication ineffective ☐ Side-effects of medication Which: ______ [9] ☐ Other (e.g. symptom free) ______ [10]
	MM month YYYY year	MM month YYYY year ☐ ongoing	☐ Trying to become pregnant ☐ Treatment duration finished ☐ Medication ineffective ☐ Side-effects of medication Which: ______ ☐ Other (e.g. symptom free) ______
	MM month YYYY year	MM month YYYY year ☐ ongoing	☐ Trying to become pregnant ☐ Treatment duration finished ☐ Medication ineffective ☐ Side-effects of medication Which: ______ ☐ Other (e.g. symptom free) ______
	MM month YYYY year	MM month YYYY year ☐ ongoing	☐ Trying to become pregnant ☐ Treatment duration finished ☐ Medication ineffective ☐ Side-effects of medication Which: ______ ☐ Other (e.g. symptom free) ______
☐ No, I have not used any hormonal treatment for endometriosis since [month/year] until today. → *Please provide the reason for not using the prescribed medication(s) by checking the appropriate box.*			☐ Trying to become pregnant ☐ Treatment duration finished ☐ Medication ineffective ☐ Side-effects of medication Which: ______ ☐ Other (e.g. symptom free) ______

2. Since we last heard from you in [month/year], have you had surgery/laparoscopy because of your endometriosis?[11]

☐ No → Go to question 3 ☐ Yes

If ***yes***, please specify the type and date of surgery (if known) in the table below (i.e. excision of lesions, removal of ovarian cyst, hysterectomy, colonoscopy, keyhole surgery, diagnostic laparoscopy) For additional space, use comment section.

Operation [12]	Date
	MM month [13] YYYY year [14]
	MM month YYYY year

Medical History

3. We last heard from you in [month/year]. Since then, have you had any of the following diseases?

Anemia[15]	☐ No	☐ Yes, diagnosed in MM month [16] YYYY year [17]		
		I was treated by a physician [66]	☐ Yes	☐ No
		I was treated with iron tablets [18]	☐ Yes	☐ No
		I was treated with an iron infusion [19]	☐ Yes	☐ No
		I was treated with a blood transfusion [20]	☐ Yes	☐ No
		Other treatment?. [21]	☐ Yes	☐ No
		If yes, which? ______ [22]		
Deep venous thrombosis OR Pulmonary embolism [23] (blood clot in the deep veins e.g. legs/arms or blood clots in the lung)	☐ No	☐ Yes, in MM month [24] YYYY year [25]		
		I was treated by a physician [26]	☐ Yes	☐ No
		I was treated with blood-thinning drugs [27]	☐ Yes	☐ No
		If yes which drugs? ______ [28]		

Depression requiring treatment 29	☐ No	☐ Yes, diagnosed in [M M] month 30 [Y Y Y Y] year 31 I was treated by a general practitioner 32 ☐ Yes ☐ No I was treated by a psychiatrist 33 ☐ Yes ☐ No I was admitted to hospital 34 ☐ Yes ☐ No Attempted Suicide 35 ☐ Yes ☐ No
Other serious diseases / operations 36 (incl. gynecological diseases, hypertension, diabetes and cancer)	☐ No	☐ Yes, which? 1. ____________ 37 When? [M M] month 38 [Y Y Y Y] year 39 I was treated by a physician 40 ☐ Yes ☐ No 2. ____________ When? [M M] month [Y Y Y Y] year I was treated by a physician ☐ Yes ☐ No *If you have had more than 2 serious diseases/operations, please use the comment field.*

Medications

4. Are you taking any other medication on a regular basis? (NOT including the medication(s) listed in question 1.) 41

☐ No ☐ Yes, which one(s)? (please use brand name if known)

____

____ 42

Hospitalization

5a. With the exception of child delivery, have you been admitted to a hospital (for at least one night) since [month/year]? 43

☐ No → Go to question 6 ☐ Yes When was it? [M M] month 44 [Y Y Y Y] year 45

If yes, was the hospital stay planned? 46
☐ No ☐ Yes

5b. What was the reason for this hospital stay? (Please be as specific as possible)

____ 47

5c. Was an operation performed? 48

☐ No ☐ Yes When was it? [M M] month 49 [Y Y Y Y] year 50

If yes, please specify the type of operation: ______________________ 51

Weight

6. What is your weight? [_ _ _] 52 kg

Pregnancy

7a. Have you had a baby since [month/year]? 53

☐ No → Go to question 8a ☐ Yes When was the delivery? [D D] day 54 [M M] month 55 [Y Y Y Y] year 56

7b. Have there been any serious health issues or problems with the newborn? 57

☐ No ☐ Yes

If yes, please specify the types of problems: ______________________ 58

Mood

We are interested in the impact of endometriosis and endometriosis treatment on your mood and whether this changes over the course of the study. Please answer these questions based on how you've felt over the <u>last 4 weeks</u>.

8a. Have you been feeling down, depressed or hopeless? 59

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

8b. Have you been feeling like you are a failure and have let down your friends and/or family? 60

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

8c. Have you felt happy or optimistic about the future? 61

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Please fill in today's date: [D D] day 62 [M M] month 63 [2 0 Y Y] year 64

Comment

Please tell us anything else you'd like to know: 65

Thank you for your help with this study!