human reproduction

pelvic pain)

## **SUPPLEMENTARY DATA**

## Supplementary data

Below are the questions asked in each cohort for self-report of endometriosis.

| Black Women's Health Study   |                |             |  |                  |             |  |
|--|----------------|-------------|--|------------------|-------------|--|
| 1995<br>Has a doctor ever told you that you have any                               | of the foll    | lowing con  | ditions? If yes, mar                   | ·k the condit    | ion and th  | ne age it was first                        |
| diagnosed  |                |             |  |                  |             |  |
| Endometriosis  | N <sub>o</sub> | Yes         | Less than 30                           | 30-39            | 40-49       | 50 or more                                 |
| 1997   |                |             |  |                  |             |  |
| If a doctor has told you that you had any of t                                     |                |             | ns, please fill in the<br>arch 1, 1995 |                  | -           | it was first diagnosed<br><b>h 1, 1995</b> |
| Endometriosis  | $\bigcirc$     |             | $\bigcirc$                             |                  |             |  |
| 1999   |                |             |  |                  |             |  |
| Between March 1997 and March 1999, if you indicate the year it was first diagnosed | were diag      | nosed with  | any of the followi                     | ng condition     | s, please f | ill in the circles and                     |
| ,  |                |             | Yes                                    | Year             | _           |  |
| Endometriosis<br>Confirmed by Iaparoscop   | у              |             | 8                                      |                  | ]           |  |
| 2001   |                |             | · ·                                    |                  |             |  |
| Between March 1999 and March 2001, if you indicate the year it was first diagnosed | were diagi     | nosed with  | any of the followi                     | ng condition     | s, please f | ill in the circles and                     |
| Endometriosis<br>Confirmed by Iaparoscop   | у              |             | Yes                                    | Year             | ]           |  |
| 2007   |                |             |  |                  |             |  |
| 2007 Have you EVER been diagnosed with any of t                                    | he followin    | ng conditio | ns?                                    |                  |             |  |
| That's you I view book angliosed with any or a                                     |                | 16 condicio | Yes                                    | Year             |             |  |
| Endometriosis (confirmed by laparo   | oscopy)        |             | $\circ$                                |                  | ]           |  |
| 2009   |                |             |  |                  |             |  |
| Since March 2007, if you were diagnosed with year it was first diagnosed           | h any of th    | e following |  |                  | rcle for ye | es and write in the                        |
| Endometriosis (confirmed by lapare   | oscopy)        |             | Yes                                    | Year             |             |  |
| 2011   |                |             |  |                  |             |  |
| Since March 2009, if you were diagnosed with year it was first diagnosed           | h any of th    | e following | conditions, please                     | e fill in the ci | rcle for ye | es and write in the                        |
| Endometriosis (confirmed by lapare   | oscopy)        |             | Yes                                    | Year             |             |  |
| 2013   |                |             |  |                  |             |  |
| Since March 2011, if you were diagnosed with year it was first diagnosed           | h any of th    | e following | conditions, please                     |                  | rcle for ye | es and write in the                        |
| Endometriosis (cells normally in the are found outside of the uterus cau           |                |             | Yes                                    | Year             |             |  |

## Etude Epidémiologique auprès de femmes de la Mutuelle Générale de l'Education Nationale (E3N) Cohort

| 1990<br>Which | of the following illn     | esses or p   | rocedures have you           | ever had?              |             |         |         |         |             |
|---------------|---------------------------|--------------|------------------------------|------------------------|-------------|---------|---------|---------|-------------|
|               |                           |              |                              |                        | Age at illr |         |         |         |             |
|               |                           | Yes          | 10 or younger                | 11-14                  | 15-19       | 20-29   | 30-39   | 40-49   | 50 or older |
|               | Endometriosis             | $\circ$      | $\circ$                      | $\circ$                | $\circ$     | $\circ$ | $\circ$ | $\circ$ | $\circ$     |
| 1992          |                           |              |                              |                        |             |         |         |         |             |
|               | and ovarian illness       | es           |                              |                        |             |         |         |         |             |
| Reporte       | ed exact age of ons       | et and diag  | gnosis and treatment         | of endom               | etriosis    |         |         |         |             |
|               |                           |              |                              |                        |             |         |         |         |             |
| 1993          | 1000 1                    |              |                              |                        |             |         |         |         |             |
| Since Ja      | nuary 1992, have yo       | ou had any   | illnesses of the uter<br>Yes | rus or ovai<br>Date of | illness     |         |         |         |             |
|               |                           |              | Mon                          |                        |             | Year    |         |         |             |
|               | Endometriosis             |              | $\cap$                       |                        |             |         |         |         |             |
|               |                           |              |                              |                        |             |         |         |         |             |
| What w        | vas the treatment?        |              |                              |                        |             |         |         |         |             |
|               | C                         |              | Yes                          |                        |             |         |         |         |             |
|               | Surgery<br>Hormone treatm | ont          |                              |                        |             |         |         |         |             |
|               | Other medical tr          |              |                              |                        |             |         |         |         |             |
|               | No treatment              | Cacificite   |                              |                        |             |         |         |         |             |
|               | Don't know                |              |                              |                        |             |         |         |         |             |
|               |                           |              |                              |                        |             |         |         |         |             |
| Please i      | ndicate the exams t       | that were    | performed for this d         | isease:                |             |         |         |         |             |
|               | D:                        |              | Yes                          |                        |             |         |         |         |             |
|               | Biopsy<br>Laparoscopy     |              |                              |                        |             |         |         |         |             |
|               | Hysterography             |              |                              |                        |             |         |         |         |             |
|               |                           |              |                              |                        |             |         |         |         |             |
|               | Hysteroscopy              |              |                              |                        |             |         |         |         |             |
|               | Ultrasound                |              |                              |                        |             |         |         |         |             |
|               | Don't know                |              |                              |                        |             |         |         |         |             |
|               |                           |              |                              |                        |             |         |         |         |             |
| 1995          |                           |              |                              |                        |             |         |         |         |             |
| Since Ju      | ne 1993, have you         | had any illi | nesses of the uterus         | or ovaries             | :?          |         |         |         |             |
|               |                           |              | Yes                          | Date of                |             |         |         |         |             |
|               | Endometriosis             |              | Mont                         | th                     | Y           | ear     |         |         |             |
|               | Endometriosis             |              | $\cup$ $\square$             |                        |             |         |         |         |             |
| What w        | as the treatment?         |              |                              |                        |             |         |         |         |             |
|               |                           |              | Yes                          |                        |             |         |         |         |             |
|               | Surgery                   |              |                              |                        |             |         |         |         |             |
|               | Hormone treatm            |              |                              |                        |             |         |         |         |             |
|               | Other medical tr          | reatment     |                              |                        |             |         |         |         |             |
|               | No treatment              |              |                              |                        |             |         |         |         |             |
|               | Don't know                |              |                              |                        |             |         |         |         |             |
| Please i      | ndicate the exams t       | that were i  | performed for this d         | isease:                |             |         |         |         |             |
| i icase i     | indicate the examp t      | criac vvere  | Yes                          | iscase.                |             |         |         |         |             |
|               | Biopsy                    |              |                              |                        |             |         |         |         |             |
|               | Laparoscopy               |              |                              |                        |             |         |         |         |             |
|               | Hysterography             |              |                              |                        |             |         |         |         |             |
|               | Hysteroscopy              |              |                              |                        |             |         |         |         |             |
|               | Ultrasound                |              |                              |                        |             |         |         |         |             |
|               | Don't know                |              |                              |                        |             |         |         |         |             |

| 1997 Since June 1990, have you had any illnesses of the uterus or ovaries?                               |   |
|--|---|
| Yes Date of illness  |   |
| Endometriosis Month Year   | ] |
| What was the treatment?  |   |
| Surgery Hormone treatment Other medical treatment No treatment Don't know                                |   |
| Please indicate the exams that were performed for this disease:  |   |
| Biopsy Laparoscopy Hysterography Ultrasound Don't know   |   |
| Don't know   |   |
| 2000   |   |
| Since April 1997, have you had any illnesses of the uterus or ovaries?  Yes  Date of illness             |   |
| Endometriosis Month Year   | ] |
| What was the treatment?  |   |
| Surgery Hormone treatment Other medical treatment No treatment Don't know                                |   |
| Please indicate the exams that were performed for this disease:  |   |
| Biopsy Laparoscopy Hysterography Hysteroscopy Ultrasound Don't know                                      |   |
| 2002   |   |
| Since July 2000, have you had any illnesses of the uterus or ovaries?  Yes  Date of illness  Month  Year |   |
| Endometriosis  | ] |
| What was the treatment?  |   |
| Surgery Hormone treatment Other medical treatment No treatment Don't know                                |   |

| Please indicate the exams that were pe  |               | this disease:    |                    |            |           |            |
|---|---------------|------------------|--------------------|------------|-----------|------------|
|   | Yes           | _                |                    |            |           |            |
| Biopsy  |               | _                |                    |            |           |            |
| Laparoscopy   |               | 4                |                    |            |           |            |
| Hysterography   |               |                  |                    |            |           |            |
| Hysteroscopy  |               |                  |                    |            |           |            |
| Ultrasound  |               | 1                |                    |            |           |            |
| Don't know  |               |                  |                    |            |           |            |
| 2005  |               |                  |                    |            |           |            |
| Since July 2002, have you had any illne   | sses of the u | terus or ovaries | •                  |            |           |            |
|   | Yes           | Date of          |                    |            |           |            |
|   |               | Month            | Year               |            |           |            |
| Endometriosis   | $\bigcirc$    |                  |                    |            |           |            |
| What was the treatment?   |               |                  |                    |            |           |            |
|   | Yes           | 7                |                    |            |           |            |
| Surgery   |               | 1                |                    |            |           |            |
| Hormone treatment   |               | 1                |                    |            |           |            |
| Other medical treatment   |               | 1                |                    |            |           |            |
| No treatment  |               |                  |                    |            |           |            |
| Don't know  |               |                  |                    |            |           |            |
| Please indicate the exams that were per Biopsy Laparoscopy Hysterography Hysteroscopy Ultrasound Don't know | Yes           | this disease:    |                    |            |           |            |
| or rough study (Co. 19)   |               |                  |                    |            |           |            |
| 2005  |               |                  |                    |            |           |            |
| Has a health care provider ever diagno  | -             | -                | V                  |            |           |            |
| Endometriosis   | יו            | 10               | Yes                |            |           |            |
| Confirmed by laparoscopy?   |               |                  | Q                  |            |           |            |
| Committee by Tapar Oscopy:  |               |                  | 0                  |            |           |            |
| 2007  |               |                  |                    |            |           |            |
| Has a doctor or other health care pro   |               | ·                | naving:            |            |           |            |
| E.L   | No            | Yes              |                    |            |           |            |
| Endometriosis   |               | $\bigcirc$       |                    |            |           |            |
| Confirmed by laparoscopy?   | 0             | $\circ$          |                    |            |           |            |
| 2010  |               |                  |                    |            |           |            |
| Have you ever been told by a health of  | are provider  | that you have ar | y of the following | illnesses? |           |            |
|   |               | -                | Year of first diag | nosis      |           |            |
|   | es No         | Before 1996      | 1996-1999          | 2000-2004  | 2005-2009 | 2010+      |
| Endometriosis   | $\bigcirc$    | $\circ$          | $\circ$            | $\circ$    | $\circ$   | $\bigcirc$ |
| Confirmed by laparoscopy?   | 0 0           |                  |                    |            |           |            |

| 2011   |              | حدد هماه ماماند | hava anv af tha fall                   | in= :  n=====2 |             |             |  |  |
|--|--------------|-----------------|--|----------------|-------------|-------------|--|--|
| Have you ever been told by a health  | Yes          | No              | Year of firs<br>Before 2004            |                | 2007-2009   | 2010+       |  |  |
| Confirmed by laparoscopy?  | Ö            | 0               | _                                      |                |             |             |  |  |
| 2013 Have you ever been told by a health   | n care pro   | vider that yo   | u have any of the foll<br>Year of firs |                |             |             |  |  |
| Endometriosis  | Yes          | No O            | Before 2006                            | 2006-2008      | 2009-2011   | 2012+       |  |  |
| Confirmed by laparoscopy?  | O            | O               |  |                |             |             |  |  |
| 2014 Have you ever been told by a health   | n care pro   | vider that yo   | Year of firs                           | st diagnosis   |             |             |  |  |
| Endometriosis  | Yes 1        | No C            | Before 2009                            | 2009-2013      | 2014+       |             |  |  |
| Confirmed by laparoscopy?  | $\bigcirc$   | O               |  |                |             |             |  |  |
| 2015 Have you ever been told by a health care provider that you have any of the following illnesses?                           |              |                 |  |                |             |             |  |  |
| Endometriosis  | Yes          | No              | Year of first<br>Before 2010           | 2010-2014      | 2015+       |             |  |  |
| Confirmed by laparoscopy?  | $\bigcirc$   | $\circ$         |  |                |             |             |  |  |
| 2016  Have you ever been told by a health care provider that you have any of the following illnesses?  Year of first diagnosis |              |                 |  |                |             |             |  |  |
| Endometriosis  | Yes          | No              | Before 2011                            | 2011-2015      | 2016+       |             |  |  |
| Confirmed by laparoscopy?  | $\circ$      | 0               |  |                |             |             |  |  |
| Nurses' Health Study II (NHSII)  |              |                 |  |                |             |             |  |  |
| 1993<br>Have you ever had any of these phy   | rsician-diag | gnosed illness  |  | _              |             |             |  |  |
| Endometriosis – Ist Dx   | Yes No       | Before 9        | Year of diagnosi<br>0/1989 9/1989-5/   |                | 91-5/1993 A | fter 6/1993 |  |  |
| Confirmed by laparoscopy   | $\circ$      | )               |  |                |             |             |  |  |
| 1995<br>Since June 1993, have you had any o  | of these ph  | nysician-diagn  |  | :-             |             |             |  |  |
| Endometriosis – Ist Dx   | Yes 1        | No Be           | Year of diagno                         | 6/1993-5/1995  | After 6/    | 1/1995      |  |  |
| Confirmed by laparoscopy   | 0 (          | $\supset$       |  |                |             |             |  |  |

| 1997                                    |                       |            |                                 |               |                |
|---|-----------------------|------------|---------------------------------|---------------|----------------|
| Since June 1995, have you had a         | ny of these           | physicia   | ın-diagnosed illnesses?         |               |                |
| ,                                       | •                     | . ,        | Year of diag                    | nosis         |                |
|   | Yes                   | No         | Before 6/1/1995                 | 6/1995-5/1997 | After 6/1/1997 |
| Endometriosis – Ist Dx                  | $\bigcirc$            |            | $\bigcirc$                      | $\cap$        | $\cap$         |
|   | $\simeq$              |            | $\circ$                         | $\circ$       | $\circ$        |
| Confirmed by laparoscopy                | $\bigcirc$            | $\bigcirc$ |                                 |               |                |
|   |                       |            |                                 |               |                |
| 1999                                    |                       |            |                                 |               |                |
| Since June 1997, have you had a         | ny of these           | physicia   | in-diagnosed illnesses?         |               |                |
| <b>,</b>                                | ,                     | F /        | Year of diag                    | nosis         |                |
|   | Yes                   | No         | Before 6/1/1997                 | 6/1997-5/1999 | After 6/1/1999 |
| Endometriosis – Ist Dx                  |                       |            |                                 |               |                |
|   | $\mathcal{Q}$         |            | $\cup$                          | $\cup$        | $\cup$         |
| Confirmed by Iaparoscopy                | ()                    | ()         |                                 |               |                |
|   |                       | •          |                                 |               |                |
| 2001                                    | 6.1                   |            | 1. 1.11 3                       |               |                |
| Since June 1999, have you had a         | ny of these           | pnysicia   |                                 |               |                |
|   | Yes                   | No         | Year of diag<br>Before 6/1/1999 | 6/1999-5/2001 | After 6/1/2001 |
| Endometriosis – Ist Dx                  | 163                   | 140        | Delore of 171777                | 0/1///-3/2001 | Aitei 0/1/2001 |
| Endometriosis – 14. DX                  | $\cup$                |            |                                 | $\circ$       | $\circ$        |
| Confirmed by laparoscopy                | $\overline{\bigcirc}$ | $\bigcirc$ | _                               | _             |                |
| Ээгин ньэг эү наран ээсэрү              | $\circ$               | $\circ$    |                                 |               |                |
| 2003                                    |                       |            |                                 |               |                |
| Since June 2001, have you had a         | ny of these           | physicia   | in-diagnosed illnesses?         |               |                |
|   | •                     |            | Year of diag                    | nosis         |                |
|   | Yes                   | No         | Before 6/1/2001                 | 6/2001-5/2003 | After 6/1/2003 |
| Endometriosis – Ist Dx                  | $\cap$                |            | $\cap$                          | $\cap$        | $\cap$         |
|   | $\simeq$              |            | $\cup$                          | $\cup$        | $\cup$         |
| Confirmed by laparoscopy                |                       | ()         |                                 |               |                |
| 2005                                    |                       |            |                                 |               |                |
| 2005<br>Since June 2002, have you had a | ov of those           | aliniaian  | diagnosad illnassas?            |               |                |
| Since June 2003, have you had a         | ly of these           | Cilliciai  | Year of diag                    | mosis         |                |
|   | Yes                   | No         | Before 6/1/2003                 | 6/2003-5/2005 | After 6/1/2005 |
| Endometriosis – Ist Dx                  |                       | 140        | Delore 6/1/2003                 | 0/2003-5/2003 | Aitel 0/1/2003 |
| Endometriosis i DX                      | Q                     | _          | $\cup$                          | $\cup$        | $\cup$         |
| Confirmed by laparoscopy                | $\bigcirc$            | $\bigcirc$ |                                 |               |                |
| , , , , , ,                             | 0                     | •          |                                 |               |                |
| 2007                                    |                       |            |                                 |               |                |
| Since June 2005, have you had a         | ny of these           | cliniciar  |                                 |               |                |
|   |                       |            | Year of diag                    |               | 4.6 4.1.10.00= |
| F 1                                     | Yes                   | No         | Before 6/1/2005                 | 6/2005-5/2007 | After 6/1/2007 |
| Endometriosis – Ist Dx                  | $\bigcirc$            |            | $\bigcirc$                      | $\bigcirc$    | $\circ$        |
| Confirmed by laparoscopy                | Ŏ                     | $\bigcirc$ | -                               | -             | _              |
|   | $\cup$                | $\cup$     |                                 |               |                |