WOMEN'S ENTRANCE QUESTIONNAIRE
Natural Procreative Technology (NPT) Evaluation
and Surveillance of Treatment for Infertility or Miscarriage

The Purpose of the Study and Women's Entrance Questionnaire

This questionnaire is part of the ongoing study to assess live birth rates among those who consider or receive Natural Procreative Technology (NPT,) treatment to conceive or maintain pregnancy. The purpose of the research is to understand the use of NPT, and characteristics that may help us predict how successful NPT will be for each couple for infertility or miscarriage.

The information you provide is important to this study, whether or not you actually get treatment with NPT, and regardless of when you begin treatment with NPT.

Your NPT physician, Dr. Yeung is a participating Investigator in this study. All information is completely confidential. You will not be identified in the results reported from this study.

We estimate that this questionnaire will take about 45 minutes to complete for most women.

Instructions for Completing the Women's Entrance Questionnaire

Thank you for your participation in this study! We appreciate your willingness to participate in this important research. Please take your time as you answer the following questions. Think carefully and remember as best you can the information requested. Please feel free to make an estimate if you are unsure of the answer.

If you begin to tire, please take a break for a few minutes to refresh yourself. If you have difficulty with a particular topic, skip it and go to topics that are less difficult. Come back to the difficult section later.

You may skip any question you are uncomfortable answering. If you choose to skip a question, either because you don't know the answer or you prefer not to answer, please place a line through the question rather than leaving it blank. (If you leave it blank we do not know whether the question was skipped accidentally or deliberately.) If you are asked to supply a number as a response, please select a whole number. Please avoid ranges of numbers and fractions of numbers.

If you have any questions or comments or feel a question is inappropriate for your situation, please write the comment at the question or at the end of questionnaire. You may also discuss any questions or comments with your NPT physician or staff.

Please turn over the page to continue.

NaProTechnology Evaluation and Surveillance of Treatment
Women's Entrance Questionnaire

Family (Last) Name _____

Given (First) Name _____

Email address for yearly surveys_____

A. Initial Information

(A-01) Today's Date |___|___| / ___|___|___| / ___|___|___|___| (*example:* 17 / Mar / 2005)
Day / **Month** / **Year**

(A-02) What is your month and year of birth? |___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(A-03) What is your marital status? (Please mark ☒ one)
☐ Never married ☐ Married ☐ Widow ☐ Divorced

→If not married, please skip to question A-06 below; if married, continue to question A-04.

(A-04) In what month and year did you marry? |___|___|___| / |___|___|___|___|
Month / **Year**
(*example:* Mar / 1985)

(A-05) Is this your first marriage?
☐ Yes ☐ No

(A-06) How did you learn about Natural Procreative Technology (NPT, NaPro)?
(Please mark ☒ all that apply)
☐ Physician or other health professional
☐ On the web
☐ Written flyer or brochure
☐ A friend or acquaintance who had NPT treatment
☐ Public presentation
☐ Church
☐ Newspaper or magazine article
☐ Other, please describe: _____

(A-07) Why have you decided to try NPT?

_____

_____

(A-08) In order to conceive or maintain pregnancy, have you at any time previously used Natural Procreative Technology (NPT, NaPro)?
☐ Yes ☐ No
If yes, in what month and year did you start NPT treatment previously? _____

(A-09) Have you ever consulted a different physician for NPT treatment?
☐ Yes ☐ No
If yes, please give name of physician_____

Please continue on the next page.

(A-10) Have you started medical treatment with NPT?
☐ Yes ☐ No
If yes, in what month and year did you start? _____
If no, in what month and year do you expect to start? _____
☐ Still undetermined (on waiting list or considering)

(A-11) Have you started charting with the Creighton Model Fertility Care System?
☐ Yes ☐ No
If yes, in what month and year did you start? _____
If no, in what month and year do you expect to start? _____
☐ Still undetermined (on waiting list or considering)

B. Trying to Have a Baby

For the purposes of this questionnaire, "trying to have a baby" means having regular sexual intercourse without any contraception, whether or not you were doing anything else to try to get pregnant.

(B-01) Using this definition, in what month and year did you start trying to have a baby with your partner?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(B-02) During the time you have been trying to have a baby, was there any time when you or your partner did something to avoid pregnancy (such as abstinence during fertile days, condoms, withdrawal, or other contraception of any kind) for more than one month?
☐ Yes ☐ No
If yes, for how many months total? _____

(B-03) During the time you have been trying to have a baby, was there any time when you and your partner did not have intercourse for more than one month?
☐ Yes ☐ No
If yes, for how many months total? _____

(B-04) During the time you have been trying to have a baby, how often do you and your partner have intercourse, in general?
_____Times per month **OR** _____Times per week

(B-05) How often do you use lubricants when you have intercourse? (Please mark ☒ one)

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

(B-06) How often is intercourse physically painful for you? (Please mark ☒ one)

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

C. Menstrual History

(C-01) At what age did you have your first menstrual period? _____ (Age)

(C-02) On average, how many days of menstrual bleeding do you have?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9 or more

(C-03) In the last year, what is the shortest menstrual cycle you have had (number of days from the beginning of one menstrual period to the next menstrual period)?
_____ number of days

Please turn over the page to continue.

(C-04) In the last year, what is the longest menstrual cycle you have had (number of days from the beginning of one menstrual period to the next menstrual period)?
_____ number of days

(C-05) What is the beginning date of your last menstrual period?

|___|___| / ___|___|___| / ___|___|___|___| (*example:* 17 / Mar / 2005)
Day / **Month** / **Year**

(C-06) How would you describe your cycles currently?
☐ Regular ☐ Irregular ☐ Both ☐ Other (describe): _____

(C-07) Have your menstrual cycles ever stopped for any reason?
☐ Yes ☐ No ☐ Unsure
If yes or unsure, please explain: _____

(C-08) Do you usually have any kind of symptoms for 4 or more days before your menstrual bleeding starts?
☐ Yes ☐ No ☐ Unsure

→If no symptoms experienced for 4 or more days, skip to question C-12 below; if yes, continue to question C-09

(C-09) Please indicate which of the following symptoms you have for 4 or more days before your menstrual bleeding starts: (Please mark ☒ all that apply)

☐ Irritability	☐ Insomnia	☐ Bloating	☐ Weight gain
☐ Salt/sweet cravings	☐ Cry easily	☐ Depression	☐ Headache
☐ Fatigue	☐ Breast tenderness	☐ Loss of control	☐ Feeling "wired"

☐ Other (describe): _____

(C-10) Referring to all the symptoms marked in question C-09, on the whole, how severe would you rate these symptoms? (Please mark ☒ one)

Minimal Extreme
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(C-11) Are these symptoms relieved with menstruation?
☐ Yes ☐ No ☐ Unsure

(C-12) How painful are your menstrual periods? (Please mark ☒ one)

Minimal Extreme
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(C-13) Do you suffer from constipation and/or diarrhea at the time of your period?
☐ Yes ☐ No ☐ Unsure

D. Gynecologic History (Female Sexual Health)

The next questions are about your health history that might affect fertility. Please answer according to your best recollection.

(D-01) How many sexual partners have you had over your lifetime? _____ (Number)

(D-02) Have you ever had a vaginal yeast infection?
☐ Yes ☐ No ☐ Unsure

(D-03) Have you ever had bacterial vaginosis?
☐ Yes ☐ No ☐ Unsure

Please continue on the next page.

(D-04) Have you ever been diagnosed with vaginal trichomonias?
☐ Yes ☐ No ☐ Unsure

(D-05) Have you ever had a vaginal infection but you are not sure what kind?
☐ Yes ☐ No ☐ Unsure

(D-06) Have you ever been diagnosed with pelvic inflammatory disease or pelvic infection?
☐ Yes ☐ No ☐ Unsure

(D-07) Have you ever been diagnosed with Chlamydia?
☐ Yes ☐ No ☐ Unsure

(D-08) Have you ever been diagnosed with gonorrhea?
☐ Yes ☐ No ☐ Unsure

(D-09) Have you ever been diagnosed with genital warts?
☐ Yes ☐ No ☐ Unsure

(D-10) Have you ever been diagnosed with genital herpes?
☐ Yes ☐ No ☐ Unsure

(D-11) Have you ever been diagnosed with any other sexually transmitted infection?
☐ Yes ☐ No ☐ Unsure
If yes or unsure, please describe: _____

(D-12) Have you ever been tested for any sexually transmitted infection (even if the test was negative)?
☐ Yes ☐ No ☐ Unsure

(D-13) Have you ever had symptoms of menopause such as hot flushes?
☐ Yes ☐ No ☐ Unsure

(D-14) Have you ever had irregular bleeding from the vagina or uterus?
☐ Yes ☐ No ☐ Unsure

(D-15) Have you ever had ovarian cysts?
☐ Yes ☐ No ☐ Unsure

(D-16) What is the month and year of your last Pap smear?
_____Month _____Year

(D-17) Have you ever had an abnormal Pap smear?
☐ Yes ☐ No ☐ Unsure

→If <u>no</u>, skip to question D-19 below; if yes, continue to question D-18.

(D-18) If yes or unsure, what kind of abnormality(ies) were noted on your Pap smear?
(Please mark ☒ all that apply)
☐ Inflammation ☐ Dysplasia ☐ Cancer ☐ Papilloma (wart) virus
☐ Abnormal cells ☐ Unsure

(D-19) Have you ever had surgery or freezing of the cervix (such as CRYO, laser, LEEP, hot cautery)?
☐ Yes ☐ No ☐ Unsure
If yes, which procedure(s)? _____

Please turn over the page to continue.

E. Family Planning History

(E-01) Have you ever used natural family planning (NFP)?
☐ Yes ☐ No
If yes:
Which NFP method(s)? _____
Over your lifetime, how long did you use or have you used NFP? _____Year(s) _____Month(s)

What is the date of your last use of NFP? |___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(E-02) Have you ever used condoms?
☐ Yes ☐ No
If yes:
Over your lifetime, how long did you use or have you used condoms? _____Year(s) _____Month(s)
What is the date of your last use of condoms?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(E-03) Have you ever used oral contraceptives (birth control pills)?
☐ Yes ☐ No
If yes:
Over your lifetime, how long did you use or have you used birth control pills?
_____Year(s) _____Month(s)
What is the date of your last use of birth control pills?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(E-04) Have you ever used the 3-month contraceptive injection (Depo Provera®)?
☐ Yes ☐ No
If yes:
Over your lifetime, how long did you use or have you used the contraceptive injection?
_____Year(s) _____Month(s)
What was the date of your last injection?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(E-05) Have you ever used any other hormone contraceptives such as Norplant®, a hormone patch, or a hormonal vaginal ring?
☐ Yes ☐ No
If yes:
Please specify name: _____
Over your lifetime, how long did you use or have you used these other hormone contraceptives?
_____Year(s) _____Month(s)
What is the month and year of your last use of these other hormone contraceptives?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

Please continue on the next page.

(E-06) Have you ever used an intrauterine device (also called IUD, IUCD, or "the coil")?
☐ Yes ☐ No
If yes:
Over your lifetime, how long did you use or have you used an IUD? _____Year(s) _____Month(s)
What is the month and year of your last use of an IUD?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(E-07) Have you ever used emergency contraception (the "morning after pill")?
☐ Yes ☐ No
If yes:
How many times? _____
What is the month and year of your last use of emergency contraception?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(E-08) Have you ever used any other method(s) of family planning?
☐ Yes ☐ No
If yes:
Please describe any other method(s) used? _____
Over your lifetime, how long did you use or have you used any other method(s)?
_____Year(s) _____Month(s)
What is the date of your last use of any other method(s)?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

F. Pregnancy History

The next questions are all about your past pregnancies.

(F-01) How many times have you ever been pregnant, counting all pregnancies, regardless of the outcome?
_____ (Number)

→If you have never been pregnant at all, please skip to question F-03.

→If you have been pregnant, please continue on the next page

(F-02) Please complete the chart below as completely as possible for each pregnancy you have ever had. If unsure of dates, please provide your best estimate.

	Month/year conception occurred	How long did it take you to get pregnant with this pregnancy?		Date pregnancy ended	How far along were you when this pregnancy ended? (i.e., 12 weeks gestation)	How did this pregnancy end? L = live birth M = miscarriage E = ectopic preg. S = stillbirth ML = molar preg. A = abortion O = other	Was this pregnancy with your current partner?	Was this pregnancy twins or more?	What was the sex of the baby(ies)? M = male F = female	What was the birth weight(s) of the baby(ies)?	Did you have medical assistance to help you conceive or maintain the pregnancy?	Did you or the baby have any complications or problems during or after the pregnancy? (If yes, please comment below)
#	Month/Year	Years	Months	Mo/Day/Yr	Weeks gestation	Please use abbreviations above to describe outcome	Please circle Y=yes N=no for each	Please circle Y=yes N=no for each	Please list all sexes or NA = not applicable	Please list all birth weights or NA = not applicable	Please circle Y=yes N=no for each	Please circle Y=yes N=no for each
1							Y N	Y N			Y N	Y N
2							Y N	Y N			Y N	Y N
3							Y N	Y N			Y N	Y N
4							Y N	Y N			Y N	Y N
5							Y N	Y N			Y N	Y N
6							Y N	Y N			Y N	Y N
7							Y N	Y N			Y N	Y N
8							Y N	Y N			Y N	Y N
9							Y N	Y N			Y N	Y N
10							Y N	Y N			Y N	Y N
11							Y N	Y N			Y N	Y N
12							Y N	Y N			Y N	Y N
13							Y N	Y N			Y N	Y N
14							Y N	Y N			Y N	Y N
15							Y N	Y N			Y N	Y N

Complications (please indicate which pregnancy number for each comment): _____

_____

_____

Please continue on the next page.

(F-03) Has your current partner ever fathered children with another partner?
☐ Yes ☐ No ☐ Unsure
If yes, what year(s) were they born? _____

G. Previous Fertility-Related Efforts

The following questions ask about things you may have done to enhance fertility, either on recommendation of a doctor, or on your own.

In order to conceive, have you at any time:

Question	Answer
(G-01) Timed intercourse by counting the number of days in your menstrual cycle?	☐ Yes ☐ No ☐ Unsure
(G-02) Taken your basal body temperature?	☐ Yes ☐ No ☐ Unsure
(G-03) Used urine LH test kits (urine ovulation test kits)?	☐ Yes ☐ No ☐ Unsure
(G-04) Taken herbs intended to enhance fertility?	☐ Yes ☐ No ☐ Unsure
(G-05) Taken vitamins intended to enhance fertility?	☐ Yes ☐ No ☐ Unsure
(G-06) Monitored vaginal discharge, cervical mucus, or cervical fluid?	☐ Yes ☐ No ☐ Unsure

H. Previous Fertility-Related Investigations

Question	Answer	Date of Most Recent Test (Month/Year)	Result
(H-01) Have you had an ultrasound of the uterus and ovaries?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-02) Have you had an ultrasound scan of the ovaries to look at ovulation (follicle tracking)?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-03) Have you had a hysterosalpingogram (x-ray assessment of the uterus and fallopian tubes)?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure

Please turn over the page to continue.

(H-04) Have you had a hysteroscopy (camera visualization of uterine cavity)?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-05) Have you had an endometrial biopsy?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-06) Have you had a D&C (scraping of lining of the womb)?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-07) Have you had a post-coital test (looking at sperm taken from your cervix after intercourse)?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-08) Have you had day 3 or early cycle blood tests?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-09) Have you had day 21 or late cycle blood tests (progesterone or ovulation)?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure
(H-10) Have you had other blood tests?	☐ Yes ☐ No ☐ Unsure		☐ Normal ☐ Abnormal ☐ Unsure

(H-11) Have you had any other investigations?
☐ Yes ☐ No
If yes, please describe: _____

Please continue on the next page.

I. Previous Fertility-Related Diagnoses

Please mark ☒ all that you have ever been told you have or suspect that you might have:

(I-01) Unexplained infertility
☐ Yes ☐ No ☐ Unsure

(I-02) Unexplained recurrent miscarriage
☐ Yes ☐ No ☐ Unsure

(I-03) Endometriosis
☐ Yes ☐ No ☐ Unsure

(I-04) Polycystic ovaries (PCOD, PCOS)
☐ Yes ☐ No ☐ Unsure

(I-05) Low progesterone
☐ Yes ☐ No ☐ Unsure

(I-06) Low estrogen
☐ Yes ☐ No ☐ Unsure

(I-07) Not ovulating
☐ Yes ☐ No ☐ Unsure

(I-08) Abnormal ovulation
☐ Yes ☐ No ☐ Unsure

(I-09) Hostile or limited cervical mucus
☐ Yes ☐ No ☐ Unsure

(I-10) Pelvic adhesions or scar tissue
☐ Yes ☐ No ☐ Unsure

(I-11) Blocked or damaged fallopian tubes
☐ Yes ☐ No ☐ Unsure

(I-12) Fibroids in or on the uterus
☐ Yes ☐ No ☐ Unsure

(I-13) Polyps in the uterus
☐ Yes ☐ No ☐ Unsure

(I-14) Luteinized unruptured follicle (LUF)
☐ Yes ☐ No ☐ Unsure

(I-16) Other
☐ Yes ☐ No
If yes, please specify: _____

J. Previous Fertility-Related Surgeries

(J-01) Which of the following surgeries have you had? Please include month and year of the surgery.

Yes	No	Surgery	Date(s) of Surgery
		Diathermy, cautery, or laser treatment for **endometriosis**	
		Ovarian diathermy, cautery, or drilling for **polycystic ovaries**	
		Laparoscopy ("keyhole surgery")	
		Laparotomy (major abdominal or pelvic surgery)	
		Ovarian Cystectomy (removal of ovarian cyst)	
		Myomectomy (removal of fibroid tumors)	
		Polypectomy (removal of polyps)	
		Tubal Reconstruction (microsurgery)	

(J-02) Have you ever had any surgery in the pelvis or reproductive organs that was not described above?
☐ Yes ☐ No
If yes, please describe: _____

(J-03) Have you ever had any other surgery anywhere in the body that was not described above?
☐ Yes ☐ No
If yes, please describe: _____

_____

K. Previous Fertility-Related Medical Treatments

(K-01) Have you taken clomiphene?
☐ Yes ☐ No
(Clomiphene is sold in different countries under different brand names, including: Clomid, Serophene, Milophene, Ardomon, Clom, Clomifene, Clomifeno, Clomifenum, Clomiphene Citrate, Clomipheni, Clomipheni Citrate, Clomivid, Clostilbegyt, C-ratioph, Dufine, Dyneric, Fertomid, Gravosan, Indovar, Klomifen, Kyliformon, Omifin, Pergotime, Phenate, Pioner, Prolifen, Serpafar, Tokormon.)

→If no, please skip to question K-09; if yes, continue to question K-02.

(K-02) For how many cycles have you taken clomiphene?
_____Total number of cycles

(K-03) What is the **maximum** dose you have taken **per day**? (Note: One tablet = 50 mg)
(Please mark ☒ one)
☐ 25 mg ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg ☐ Other, please specify: _____

(K-04) What is the number of days you took this dose? (Please mark ☒ one)
☐ 3 ☐ 4 ☐ 5 ☐ Other, please specify: _____

(K-05) Did you take anything along with the clomiphene to enhance mucus?
☐ Yes ☐ No
If yes, what medication did you take? _____

(K-06) Was the treatment with clomiphene monitored with blood tests?
☐ Yes ☐ No

(K-07) Was the treatment with clomiphene monitored with ultrasound?
☐ Yes ☐ No

(K-08) How severe were the side effects you experienced while taking clomiphene?
(Please mark ☒ one)

None	Mild	Moderate	Severe	Unsure
☐	☐	☐	☐	☐

(K-09) Other than clomiphene, have you at any time taken any other medication by mouth to induce ovulation?
☐ Yes ☐ No
If yes, what medication(s) did you take? _____

(K-10) In order to achieve pregnancy, have you at any time taken any medication by injection to induce ovulation?
☐ Yes ☐ No
If yes, what medication(s) did you take? _____

(K-11) In order to achieve pregnancy, have you at any time taken progesterone by prescription?
☐ Yes ☐ No

(K-12) In order to achieve pregnancy, have you at any time taken any other medications to enhance fertility?
☐ Yes ☐ No
If yes, please describe: _____

(K-13) Have you had artificial insemination?
☐ Yes ☐ No
If yes, please indicate the following:
How many cycles with husband's sperm? _____
How many cycles with donor sperm? _____

L. Previous Assisted Reproductive Technology (ART)

These next questions are about in-vitro fertilization (IVF) or similar ART treatments, such as intra-cytoplasmic sperm injection (ICSI), gamete intra-fallopian transfer (GIFT), or zygote intra-fallopian transfer (ZIFT). By ART treatment, we mean any treatment that involves removing the egg from the woman's body and then replacing the egg or embryo back into the body.

(L-01) Have you ever been advised by a physician or practitioner to try IVF, ICSI, or any other ART?
☐ Yes ☐ No

(L-02) Have you ever attempted IVF, ICSI or any other ART?
☐ Yes ☐ No

→If no, please skip to Section M, Experience of Past Fertility Treatment; if yes, continue to question L-03

(L-03) If yes, please complete the following table for **all** IVF, ICSI, or any ART attempts, regardless of outcome:

Attempt	Date of Attempt		Number of eggs retrieved	Number of embryos created	Number of embryos transferred	Number of embryos frozen
	Month	Year				
1						
2						
3						
4						
5						
6						

M. Experience of Past Fertility Treatment

(M-01) Have you or your partner ever been evaluated or treated for fertility problems or miscarriage in the past, not including NPT (NaPro Technology)?

☐ Yes ☐ No

→If no, please skip to Section N, Adoption,; if yes, continue to question M-02.

In the next questions, please consider your overall experience with medical evaluation and treatment for infertility or miscarriage that you and your partner have had in the past (not including NPT). Please answer from your own perspective, not necessarily your partner's.

How do you assess the doctors and the staff that you have worked with?

(M-02) Did they make you feel you had enough time during the consultations? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-03) Did they involve you in decisions? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-04) Did they listen to you? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-05) Did they explain the purpose of examinations, tests, and treatments? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-06) Did they tell you what you wanted to know about the causes of infertility and/or miscarriage? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-07) Did they tell you what you wanted to know about the treatment of infertility and/or miscarriage? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-08) Did they deal with emotional consequences of your infertility or miscarriage and treatment? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-09) Did they make a treatment plan adjusted to your special situation? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(M-10) What have you liked most about you and your partner's past treatment?

_____

_____

_____

(M-11) What have you liked least about you and your partner's past treatment?

_____

_____

_____

(M-12) What is your overall satisfaction rating for you and your partner's past treatment, rated from 1-10? (Please mark ☒ one)

Not at all satisfied ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Satisfied

N. Adoption

(N-01) Have you ever applied for adoption?
☐ Yes ☐ No

(N-02) Do you have any adopted children?
☐ Yes ☐ No

(N-03) Have you ever had foster children?
☐ Yes ☐ No

(N-04) Do you currently have any foster children?
☐ Yes ☐ No

P. General Health History

(P-01) Which of the following conditions have you ever had? (Please mark ☒ all that apply)

☐ Migraine headaches	☐ Anemia	☐ Urinary tract infections
☐ Varicose veins	☐ Allergies such as hay fever	☐ Allergic skin reaction
☐ Seizures	☐ Thyroid disease	☐ Rheumatoid arthritis
☐ High blood pressure	☐ Heart disease	☐ Blood clots
☐ Kidney disease	☐ Liver disease	☐ Chronic fatigue syndrome
☐ Fibromyalgia	☐ Multiple sclerosis	☐ Crohn's disease
☐ Ulcerative colitis	☐ Lupus erythematosus	☐ Sjogren's syndrome
☐ Scleroderma	☐ Frequent diarrhea	☐ Frequent constipation
☐ Non-insulin-dependent diabetes mellitus		☐ Insulin-dependent diabetes mellitus

☐ Cancer (describe): _____
☐ Hormone problems (describe): _____
☐ Other autoimmune disease (describe): _____
☐ Food intolerance (describe): _____
☐ Other medical problems (describe): _____
☐ None

(P-02) Do you have any drug allergies?
☐ Yes ☐ No
If yes, please describe: _____

(P-03) Please list all drugs, vitamins, or herbs you are currently taking on a regular basis, whether they are prescribed or over-the-counter:
_____
_____
_____

(P-04) What has been your lowest weight as an adult?
_____Pounds
or _____Kilograms

(P-05) What has been your highest weight as an adult (not including any pregnancy)?
_____Pounds
or _____Kilograms

(P-06) What is your current weight?
_____Pounds
or _____Kilograms

(P-07) Have you ever experienced unexplained increases in your weight?
☐ Yes ☐ No ☐ Unsure

(P-08) Have you ever experienced unexplained decreases in your weight?
☐ Yes ☐ No ☐ Unsure

(P-09) Has a medical professional ever expressed a concern about your weight?
☐ Yes ☐ No ☐ Unsure

(P-10) Have you ever had an eating disorder (such as anorexia, bulimia, or others)?
☐ Yes ☐ No

(P-11) Have you been immunized against rubella (German measles)?
☐ Yes ☐ No ☐ Unsure

In general, how much do you experience the following symptoms: (Please mark ☒ one for each)

(P-12) Fatigue

Minimal									Extreme
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

(P-13) Sleep Disturbance

Minimal									Extreme
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

(P-14) Low Mood or Feeling Depressed

Minimal									Extreme
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

(P-15) Anxiety

Minimal									Extreme
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

(P-16) Do you have unwanted/excessive hair growth?
☐ Yes ☐ No ☐ Unsure

(P-17) Do you suffer from acne?
☐ Yes ☐ No ☐ Unsure

(P-18) Do you have dizziness or light headedness before meals?
☐ Yes ☐ No ☐ Unsure

The next 10 questions address potential environmental or occupational exposures. Please indicate whether you have had a significant exposure to each of these. (Please mark ☒ one for each)

(P-19) Ionizing radiation other than medical x-rays (gamma rays, x-rays, alpha and beta particles, neutrons).
☐ Yes ☐ No ☐ Unsure

(P-20) Magnetic radiation from towers (electromagnetic energy radiated or transmitted as rays or waves).
☐ Yes ☐ No ☐ Unsure

(P-21) Chemical solvents (liquid substance capable of dissolving other substances).
☐ Yes ☐ No ☐ Unsure

(P-22) High noise levels (such as jack hammering, rock concerts, headsets with high volume).
☐ Yes ☐ No ☐ Unsure

(P-23) Heavy metals (such as lead, cadmium, or mercury).
☐ Yes ☐ No ☐ Unsure

(P-24) Pesticides (chemicals used to kill insects).
☐ Yes ☐ No ☐ Unsure

(P-25) Herbicides (chemicals used to kill weeds or unwanted plants).
☐ Yes ☐ No ☐ Unsure

(P-26) Water pollution (water contaminated with sewage, chemicals, or fertilizers).
☐ Yes ☐ No ☐ Unsure

(P-27) Air pollution (smog or particular matter).
☐ Yes ☐ No ☐ Unsure

(P-28) Other
☐ Yes ☐ No ☐ Unsure

If yes, please describe: _____

Q. Family History

The next few questions are about family history that might relate to your fertility.

(Q-01) Do your biologic mother or father or your siblings have a history of infertility, miscarriages, or other reproductive problems?
☐ Yes ☐ No ☐ Unsure
If yes or unsure, please describe: _____

(Q-02) Did your biologic mother take hormones (such as DES) when she was pregnant with you?
☐ Yes ☐ No ☐ Unsure

(Q-03) Which of the following conditions has your biologic mother, father, siblings, grandparents, cousins, nieces, or nephews ever had? (Please mark ☒ all that apply)

☐ Rheumatoid arthritis ☐ Multiple sclerosis ☐ Crohn's disease
☐ Ulcerative colitis ☐ Lupus erythematosus ☐ Sjogren's syndrome
☐ Scleroderma ☐ Thyroid disease ☐ Insulin-dependent diabetes mellitus
☐ Non-insulin-dependent diabetes mellitus
☐ Other autoimmune disease (describe): _____
☐ None

(Q-04) Does your biologic family have genetic conditions that may be passed on?
☐ Yes ☐ No ☐ Unsure
If yes or unsure, please describe: _____

(Q-05) Does your partner's biologic family have genetic conditions that may be passed on?
☐ Yes ☐ No ☐ Unsure
If yes or unsure, please describe: _____

R. Health Habits

(R-01) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes that made you SWEAT and BREATHE HARD, such as fast walking, jogging, swimming laps, playing tennis, fast bicycling, heavy yard work or housework, or similar aerobic activities? (Please mark ☒ one)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

(R-02) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes but less vigorously than described above? (Please mark ☒ one)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

(R-03) Have you ever smoked cigarettes?
☐ Yes ☐ No

→**If no, please skip to question R-05 below; if yes, continue to question R-04.**

(R-04) Do you currently smoke cigarettes?
☐ Yes ☐ No
If yes, how many cigarettes do you usually smoke per day? _____
If no, in what month and year did you quit smoking cigarettes?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(R-05) Have you ever used tobacco in any other form (pipes, cigars, snuff, chewing tobacco, etc.)?
☐ Yes ☐ No

→**If no, please skip to question R-07 below; if yes, continue to question R-06.**

(R-06) Do you currently use tobacco in some form?
☐ Yes ☐ No
If no, in what month and year did you quit using tobacco?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(R-07) On average during the last month, how many cups of coffee did you drink per **day**?
(**Do not count espresso**) (Please mark ☒ one)

☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(R-08) On average during the last month, how many cups of espresso did you drink per **day**?
(Please mark ☒ one)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(R-09) On average during the last month, how many cans or bottles of caffeinated soda drinks did you drink per **day**, including Coca Cola, Pepsi, and others? (Please mark ☒ one)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(R-10) On average, how many units of alcohol do you drink per **week**? (Please mark ☒ one)
(1 unit = glass (half-pint) of beer, 1 measure of spirits, 1 small glass of wine)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(R-11) In the last month, what is the highest number of units of alcohol you had in a **24-hour period**?
(Please mark ☒ one)
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8-9 ☐ 10-12 ☐ 13-15 ☐ over 15

S. Stress and Social Situation

Please answer the following questions from your own perspective, not necessarily your partner's.

(S-01) With reference to you or your partner's fertility problems and treatment, do you feel that:
[Please mark ☒ one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My life has changed very much	☐	☐	☐	☐	☐
My life has been disrupted as a result	☐	☐	☐	☐	☐
It is stressful for me to deal with	☐	☐	☐	☐	☐

(S-02) How have you or your partner's fertility problems affected your marriage/partnership?
[Please mark ☒ one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Brought us closer together	☐	☐	☐	☐	☐
Strengthened our relationship	☐	☐	☐	☐	☐
Caused crisis in our relationship	☐	☐	☐	☐	☐
Caused thoughts of divorce	☐	☐	☐	☐	☐

(S-03) How much stress has you or your partner's fertility problems placed on the following?
[Please mark ☒ one answer for each line]

	A lot	Some	A little	None
Your marriage/partnership	☐	☐	☐	☐
Your sex life	☐	☐	☐	☐
Your relationships with your family	☐	☐	☐	☐
Your relationships with your family-in-law	☐	☐	☐	☐
Your relationships with friends	☐	☐	☐	☐
Your relationships with workmates	☐	☐	☐	☐
Your relationships to people with children	☐	☐	☐	☐
Your relationships to pregnant women	☐	☐	☐	☐
Your physical health	☐	☐	☐	☐
Your mental health	☐	☐	☐	☐
Your financial condition	☐	☐	☐	☐

(S-04) Do you get support and understanding from any of the following people in relation to you or your partner's fertility problems or treatment? [Please mark ☒ one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	☐	☐	☐	☐	☐	☐
Partner	☐	☐	☐	☐	☐	☐
Partner's Family	☐	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐	☐
Colleagues	☐	☐	☐	☐	☐	☐
Others	☐	☐	☐	☐	☐	☐

Who? _____

(S-05) Do you experience that some people react negatively to you or your partner's fertility problems or treatment? [Please mark ☒ one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	☐	☐	☐	☐	☐	☐
Partner	☐	☐	☐	☐	☐	☐
Partner's Family	☐	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐	☐
Colleagues	☐	☐	☐	☐	☐	☐
Others	☐	☐	☐	☐	☐	☐

Who? _____

T. Demographic Information

(T-01) How many years of schooling have you had? (Please mark ☒ one)
☐ 8 or less ☐ 9-10 ☐ 11-12 ☐ 13-15 ☐ 16-18 ☐ more than 18

(T-02) What is your race and ethnicity? (Please mark ☒ all that apply)
☐ Aborigine ☐ Alaskan Native ☐ American Indian/Native American ☐ Asian
☐ Black ☐ Hawaiian Native ☐ Hispanic/Latino ☐ Pacific Islander ☐ White
☐ Other, please specify: _____

(T-03) What is your religious preference? (Please mark ☒ one)
☐ Catholic ☐ Islamic ☐ Jewish ☐ Latter-day Saint ☐ Orthodox Christian
☐ Protestant ☐ None ☐ Other, please specify: _____

(T-04) About how often do you usually attend religious or worship services? (Please mark ☒ one)
☐ More than once per week ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never

(T-05) What is your current occupation? (Please mark ☒ one)
☐ Professional ☐ Technical ☐ Clerical/Sales ☐ Skilled laborer ☐ Unskilled laborer
☐ Homemaker ☐ Student ☐ Educator
☐ Other, please specify: _____

(T-06) What is your approximate yearly total household income? (Please mark ☒ one)
☐ Under 12,000 ☐ 12,001-25,000 ☐ 25,001-50,000 ☐ 50,001-75,000
☐ 75,001-100,000 ☐ Over 100,000

(T-07) Please specify what denomination of currency is used for the figure in the previous question. (Please mark ☒ one)
☐ Australian Dollars ☐ Canadian Dollars ☐ Euros ☐ Pounds ☐ U.S. Dollars
☐ Other, please specify: _____

Thank you for your participation in this important study.