Welcome to the Ovulation and Menstruation Health Study

Thank you for agreeing to participate in this important study on menstrual health and for providing information that may be valuable to many women in the future. If you complete this survey, you will be entered into a raffle to win a $200 gift card. You may be eligible to complete other follow-up surveys. If you are eligible, we may contact you in the future about them. If you have any questions about the study, please contact the Study Coordinator by phone [redacted] or at [redacted]

Instructions

You must click 'Submit' on each page to save your answers. However, once you click submit you will be taken to the next form and cannot go back. The 'Submit' button is at the bottom of each page.

There is an option to increase or decrease font on the top right corner of the page.

If you are unable to complete the whole survey in one sitting, you can click 'Save & Return Later' and follow the instructions that will appear on the screen. The system will display a return code which you must copy or write down, and an email with a special link for continuing the survey will be sent to you. When you wish to complete the survey, click on the link in the email and when the system asks, enter the provided return code. If you lose or forget your return code, you can contact the Study Coordinator by phone at [redacted] or at [redacted] for assistance.

This REDCap print out does not make clear the skip patterns embedded in the online survey instrument.

About You

First Name:

_____

Middle name or initial:

_____

Last name:

_____

Secondary Contact Information

Please provide at least one other form of contact, in case the primary email does not function.

Telephone number:

_____

We would really like to be able to keep in touch with you about the study. We will only contact you about this or future surveys.

Do you have another e-mail address that we could use in case your current e-mail address is no longer active?

◯ Yes
◯ No

Alternate email address:

_____

Confirm alternate email address:

_____

Note! Email and confirm email address must match.

Medical Record Validation

Do you currently live in the USA?

◯ Yes
◯ No

Which state do you live in?

◯ Alabama
◯ Alaska
◯ Arizona
◯ Arkansas
◯ California
◯ Colorado
◯ Connecticut
◯ Delaware
◯ Florida
◯ Georgia
◯ Hawaii
◯ Idaho
◯ Illinois
◯ Indiana
◯ Iowa
◯ Kansas
◯ Kentucky
◯ Louisiana
◯ Maine
◯ Maryland
◯ Massachusetts
◯ Michigan
◯ Minnesota
◯ Mississippi
◯ Missouri
◯ Montana
◯ Nebraska
◯ Nevada
◯ New Hampshire
◯ New Jersey
◯ New Mexico
◯ New York
◯ North Carolina
◯ North Dakota
◯ Ohio
◯ Oklahoma
◯ Oregon
◯ Pennsylvania
◯ Rhode Island
◯ South Carolina
◯ South Dakota
◯ Tennessee
◯ Texas
◯ Utah
◯ Vermont
◯ Virginia
◯ Washington
◯ West Virginia
◯ Wisconsin
◯ Wyoming

Have you ever received care at Boston Medical Center?

◯ Yes
◯ No

We would like to look at your medical records in order to study other factors associated with menstrual health. You will be entered into the raffle regardless of your response. All study data is protected by HIPAA-compliant equipment and software.

◯ Yes, it is OK to check my medical record
◯ No, please do not check medical record

In order for us to see your medical records, we need your date of birth and current address.

Date of birth:

_____

Street Address:

_____

City:

_____

Zipcode:

_____

Date About You form was submitted:

_____

Baseline Questionnaire

We would like to start by asking some questions about your background. Lets start with where you are from.

Were you born in the United States of America?

◯ Yes
◯ No

In what city and state were you born?

City:

_____

State:

◯ Alabama
◯ Alaska
◯ Arizona
◯ Arkansas
◯ California
◯ Colorado
◯ Connecticut
◯ Delaware
◯ Florida
◯ Georgia
◯ Hawaii
◯ Idaho
◯ Illinois
◯ Indiana
◯ Iowa
◯ Kansas
◯ Kentucky
◯ Louisiana
◯ Maine
◯ Maryland
◯ Massachusetts
◯ Michigan
◯ Minnesota
◯ Mississippi
◯ Missouri
◯ Montana
◯ Nebraska
◯ Nevada
◯ New Hampshire
◯ New Jersey
◯ New Mexico
◯ New York
◯ North Carolina
◯ North Dakota
◯ Ohio
◯ Oklahoma
◯ Oregon
◯ Pennsylvania
◯ Rhode Island
◯ South Carolina
◯ South Dakota
◯ Tennessee
◯ Texas
◯ Utah
◯ Vermont
◯ Virginia
◯ Washington
◯ West Virginia
◯ Wisconsin
◯ Wyoming

In what country were you born?

_____
(Please write in the name of the country.)

Which categories describe you? (Check all that apply)
(Check all that apply)

☐ White German, Irish, English, Italian, Polish, French, etc.
☐ Hispanic, Latina, or Spanish Origin Mexican, Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, etc
☐ Black or African American African American, Jamaican, Hatian, Nigerian, Ethiopian, Somalian, etc.
☐ East Asian Chinese, Japanese, Korean, Mongolian, Taiwanese, etc.
☐ Southeast Asian Burmese, Cambodia, Hmong, Indonesian, Laotian, Malaysian, Filipino, Thai, Vietnamese, etc.
☐ South Asian Asian Indian, Bangladeshi, Bhutanese, Maldivian, Nepalese, Pakistani, Sri Lankan, etc.
☐ American Indian or Alaskan Native Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.
☐ Middle Eastern or North African Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.
☐ Native Hawaiian or Other Pacific Islander Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
☐ Some other race, ethnicity, or origin.

What is the highest level of education that you have completed?

◯ 8th grade or less
◯ Some high school, but did not graduate
◯ High school graduate or GED
◯ Some college or 2-year degree
◯ 4-year college graduate
◯ More than 4-year college degree

What is your total annual household income before tax?

◯ Below $15,000
◯ $15,000 $24,999
◯ $25,000 $49,999
◯ $50,000 $74,999
◯ $75,000 $99,999
◯ $100,000 $124,999
◯ $125,000 $149,999
◯ $150,000 $199,999
◯ $200,000 or more
◯ Prefer not to answer
◯ Don't know

How many people, including yourself, are supported by this income? Please include all children, parents, grandparents, and relatives who are supported in any way by this income, no matter where they live.

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12

Are you currently working at a job for pay?

◯ Yes
◯ No

Have you ever worked a job where you worked at least some time between midnight and 4:00AM?

◯ Yes
◯ No

In the last month, about how many hours did you sleep each day?

◯ 4 hours or less
◯ 5-7 hours
◯ 8-9 hours
◯ 10 or more hours

In the last month, have you generally gone to sleep at the same time every day?

◯ Yes
◯ No

Have you ever been homeless for any period of time?

◯ Yes
◯ No

Date Demographics form was submitted:

_____

Anthropometrics

The next questions are about your height and weight.

What is your current height without shoes?
Please select if you are responding in feet and inches or centimeters.

◯ Feet and inches
◯ Centimeters

Feet:

_____

Inches:

_____

Centimeters:

_____

How much do you weigh currently?
Please select if you are responding in pounds or kilograms.

◯ Pounds
◯ Kilograms

Pounds:

_____

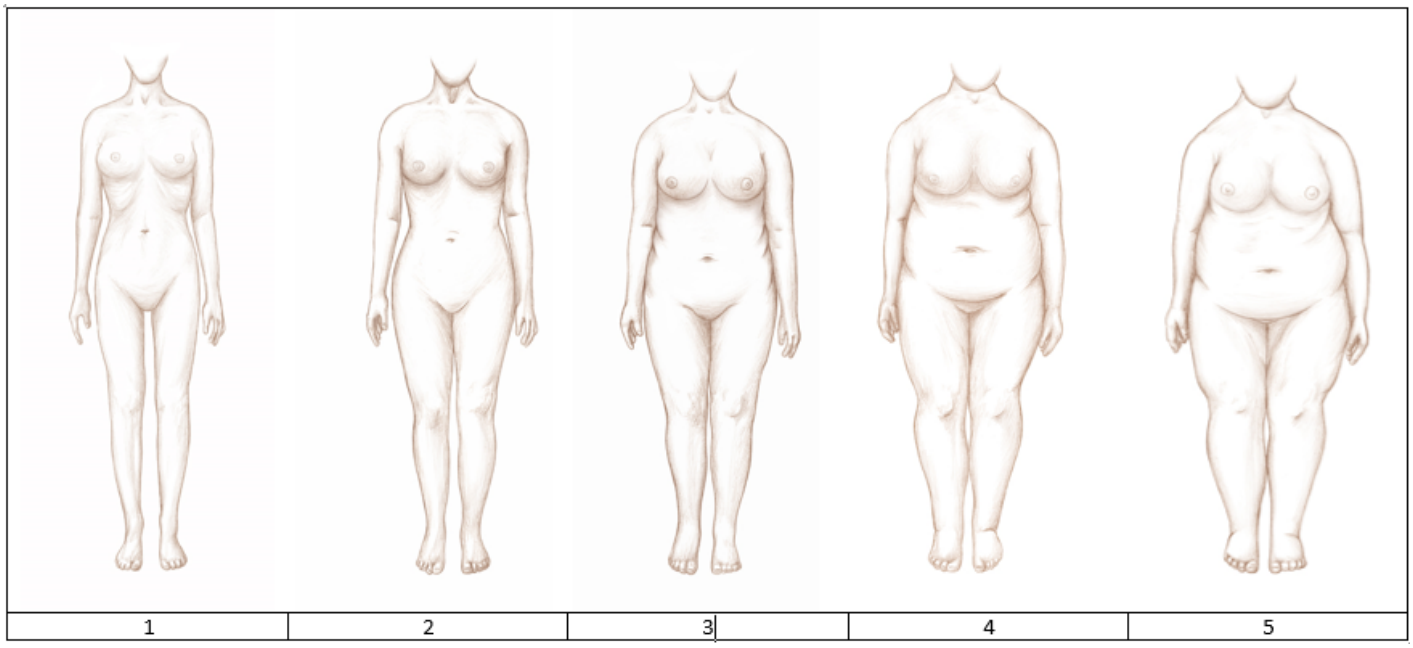
Kilograms:

_____

When you gain weight, where on your body do you mainly tend to add the weight?
(Check all that apply)

☐ Around the waist/stomach
☐ Around the hips and thighs
☐ Around the chest and shoulders
☐ Equally all over
☐ Other
☐ Don't gain weight

Body Shape



Which image above looks most like your body shape now?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Now think about when you were 18 years old. Which image above looks most like your body shape when you were 18?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

About how much did you weigh when you were 18 years old?
Please select if you are responding in pounds or kilograms.

◯ Pounds
◯ Kilograms

Pounds:

_____

Kilograms:

_____

Date Anthropometrics form was submitted:

_____

Menstrual Cycle

The next questions are about your menstrual periods.

At what age did you have your first menstrual period?

◯ 7 years old or younger
◯ 8 - 10 years old
◯ 11 years old
◯ 12 years old
◯ 13 years old
◯ 14 years old
◯ 15 years old
◯ 16 years old or older
◯ Don't remember

Sometimes when a woman first gets her period, it's not on a regular schedule and she may go months between periods. Thinking back to when you first got your period, how long did it take for your menstrual periods to become regular?

◯ My periods became regular in less than 1 year
◯ It took 1-2 years before my periods became regular
◯ It took 3-4 years before my periods became regular
◯ It took 5 or more years before my periods became regular
◯ My periods never became regular

Did your period become regular on its own - that means without taking the Pill or using any other hormonal contraceptives (patch, implants, or injectables)?

◯ Yes, it became regular on its own
◯ No

Has there ever been a time when your menstrual period was NOT regular or predictable for more than a 3 month window of time?

◯ Yes
◯ No

Why do you think were your periods were irregular?
(Check all that apply)

☐ Stress
☐ Polycystic ovary syndrome (PCOS)
☐ Hormonal abnormality
☐ Too much exercise and not eating enough
☐ Overweight/obesity
☐ Pregnancy/breastfeeding
☐ Other, please specify
☐ Don't know

If Other, please specify:

We are interested in whether your menstrual period is regular now - that means you can usually predict about when the next period will start. Would you say that your period is usually regular?

◯ Yes
◯ No

Now we want to know about how long your period usually lasts. Counting only the days when you were bleeding and not when you were spotting, in the last year about how many days did your period usually last?

◯ Less than 3 days
◯ 3 days
◯ 4 days
◯ 5 days
◯ 6 days
◯ 7 days
◯ 8 or more days

Now we want to know about your menstrual cycle length - that is the number of days from the first day of one menstrual period to the first day of your next period. Normal menstrual cycle lengths range from 21 to 35 days. In the last year, about how long is your typical menstrual cycle length?

_____
(Number of days)

1=Out of Range

_____

☐ Don't Know

If you had to take a guess, about how long is your typical menstrual cycle length?

◯ 21-25 days long
◯ 26-29 days long
◯ 30-31 days long
◯ 32-35 days long
◯ 35-39 days long
◯ 40 days long or more
◯ I'm still not sure

Information on menstrual cycle length is very important for the accuracy of this study. Please double check that you have entered your information correctly. Are you sure your typical menstrual cycle is [period_length] days long?

◯ Yes
◯ Go back to change answer

In the last 12 months, how many menstrual periods did you have?

_____

1=Out of Range

_____

☐ Don't Know

Are you sure you had [period_12mon] periods in the last 12 months?

◯ Yes
◯ Go back to change answer

Do you keep track of your menstrual cycle?

◯ Yes
◯ No

What do you use to track your menstrual cycle?

◯ Written (paper) calendar
◯ Phone app
◯ Software program
◯ Something else

Please write the name of the app or program you use:

_____

Please describe what else you use to track your menstrual cycle.

Date Menstrual Cycle form was submitted:

_____

Contraceptive History

The next questions focus on your use of contraceptives or hormones.

Hormonal contraceptives include the pill, patch, implants, or injectables. Have you ever used hormonal contraceptives?

◯ Yes
◯ No

How old were you when you first started using hormonal contraceptives?

_____

☐ Don't Remember how old I was

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Are you sure you were [hormone_age] old when you first started using hormonal contraceptives? Please review your response above.

Why did you first start using hormonal contraceptives?
(Check all that apply)

☐ To prevent pregnancy
☐ To regulate my menstrual periods
☐ To reduce menstrual pain
☐ To treat acne
☐ Other

If Other, please describe.

Which of the following hormonal contraceptives have you ever used?
(Check all that apply)

☐ Oral contraceptive pill
☐ Contraceptive patch
☐ Injectable, such as Depo-Provera
☐ Vaginal ring
☐ Implantable rods
☐ Hormone-containing intrauterine device (IUD), such as Mirena or Progestasert
☐ Other

If Other, please describe.

Do you currently use any hormonal contraceptives?

◯ Yes
◯ No

Are you currently taking hormonal contraceptives to help regulate your menstrual periods so they are more regular and predictable?

◯ Yes
◯ No

When did you stop using hormonal contraceptives?

_____
(Age.)

☐ Don't Remember what age I stopped

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

The age you entered is before the age you said you started using hormonal contraceptives. Please review your response above.

Why did you stop using hormonal contraceptives?
(Check all that apply)

☐ Didn't like how hormones make me feel
☐ Trying to get pregnant
☐ Other

If Other, please describe.

Now think about all the different times you've used hormonal contraception in your life. If you had an injection or implant, include the time it was effective. Counting only the times you were taking it, for how many years did you use hormonal contraception?

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12
◯ 13
◯ 14
◯ 15
◯ 16
◯ 17
◯ 18
◯ 19
◯ 20
◯ 21
◯ 22
◯ 23
◯ 24
◯ 25

☐ I took it less than 12 months

Number of Months:

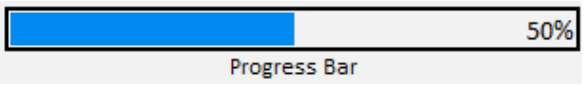
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12

Date Contraceptive History form was submitted:

_____

Health and Body

The next questions are about your current health and body.



Overall, how would you rate your current health?

◯ Excellent
◯ Very Good
◯ Good
◯ Fair
◯ Poor

How would you describe your health compared to other people your age?

◯ Better than most
◯ About the same as most
◯ Worse than most

During the last 12 months, about how many times did you visit your family physician or primary care provider for care for yourself?

◯ None
◯ Once
◯ 2-3 times
◯ 4-5 times
◯ 6 or more times

Do you take a multivitamin or prenatal vitamin regularly?

◯ Yes
◯ No

Thinking about your face or back, how would you rate your acne? If your acne changes during your menstrual cycle, please think about the acne at its worst.

◯ None or rare acne (none to a couple of pimples)
◯ Mild acne (4 or more pimples)
◯ Moderate acne (4 or more pimples that are red and irritated)
◯ Severe acne (4 or more pimples that are red, irritated, and have pus)

Do you have more hair on your face or body than you would like?

◯ Yes
◯ No

How hairy are you compared to other female members of your family?

◯ As hairy
◯ Less hairy
◯ More hairy

Other than the underarms, legs, eyebrows, and pubic hair, do you regularly remove hair from any other areas of your body?

◯ Yes
◯ No

Which of the following areas do you remove hair from?
(Check all that apply)

☐ Upper lip
☐ Chin
☐ Chest
☐ Upper abdomen
☐ Lower abdomen
☐ Upper arms (not underarms/armpits)
☐ Upper back
☐ Lower back

This question is not about your underarms, legs, eyebrows, or pubic hair. Thinking only about the areas of your body you answered about in the last question, what methods have you used to remove hair from them?
(Check all that apply)

☐ Shaving
☐ Waxing
☐ Plucking
☐ Threading
☐ Laser hair removal
☐ Electrolysis
☐ Spironolactone
☐ Vaniqa
☐ Hair removal creams or gel
☐ Other

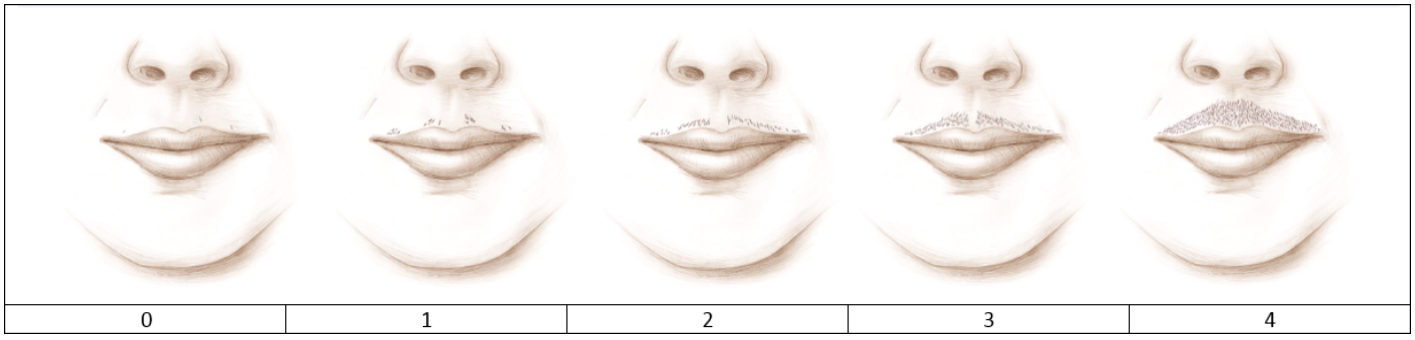
If Other: What other methods of hair removal have you used?

In the last year, how often did you use shaving, waxing, plucking, threading, creams, or gels on any area of your body other than underarms, legs, or eyebrows?

◯ Daily
◯ Three times a week
◯ Twice a week
◯ Weekly
◯ Twice a month
◯ Monthly

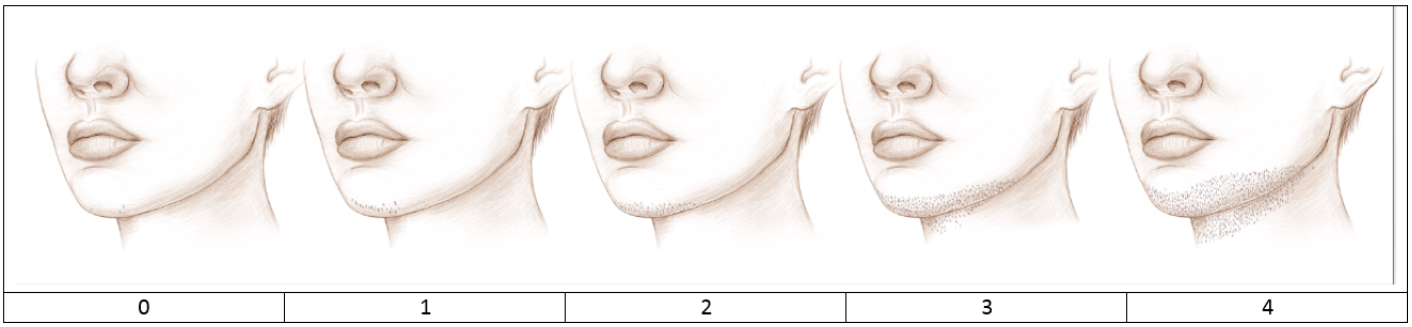
For the next questions, we want to know about how much coarse or thick hair you have on different parts of your body. When you answer, please think about your natural body state - that means how much hair you have when you are not using hair removal procedures or treatment. You can use the images as a guide, but remember your own hair pattern may be slightly different.

How much coarse or thick hair do you have on your upper lip?



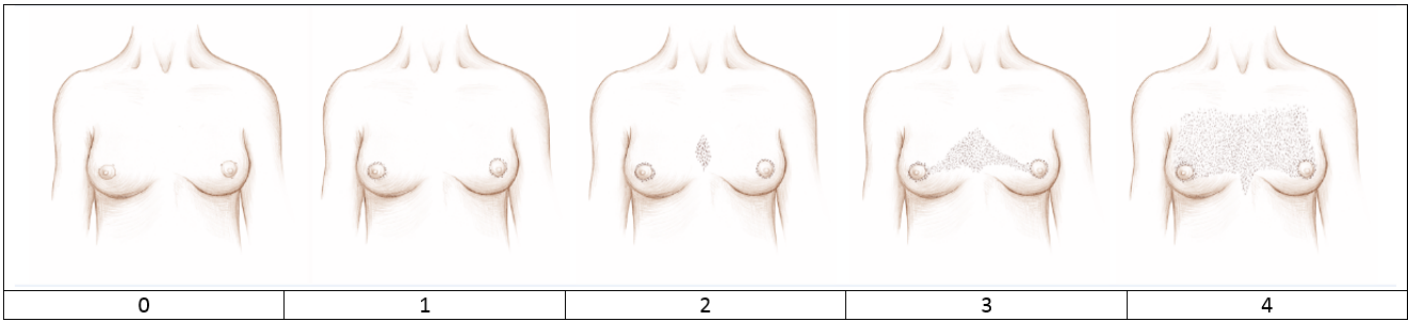
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much coarse or thick hair do you have on your chin?



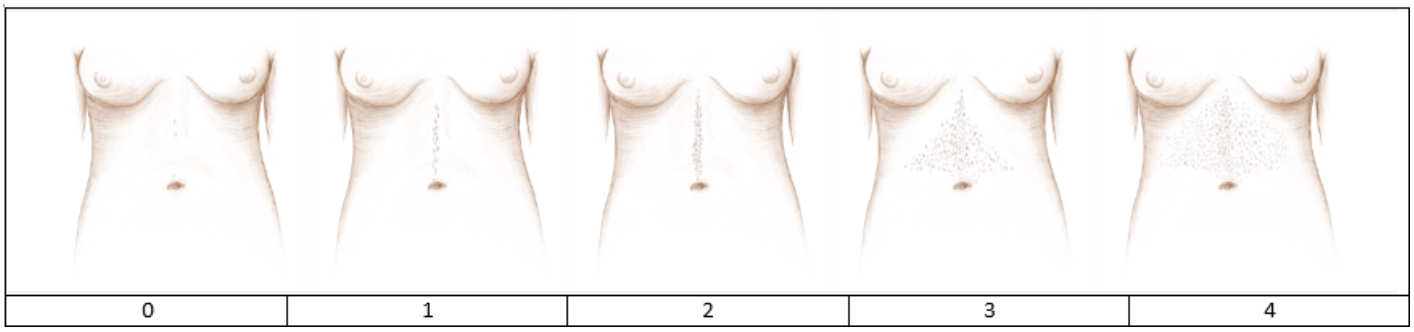
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much coarse or thick hair do you have on your chest and nipple area?



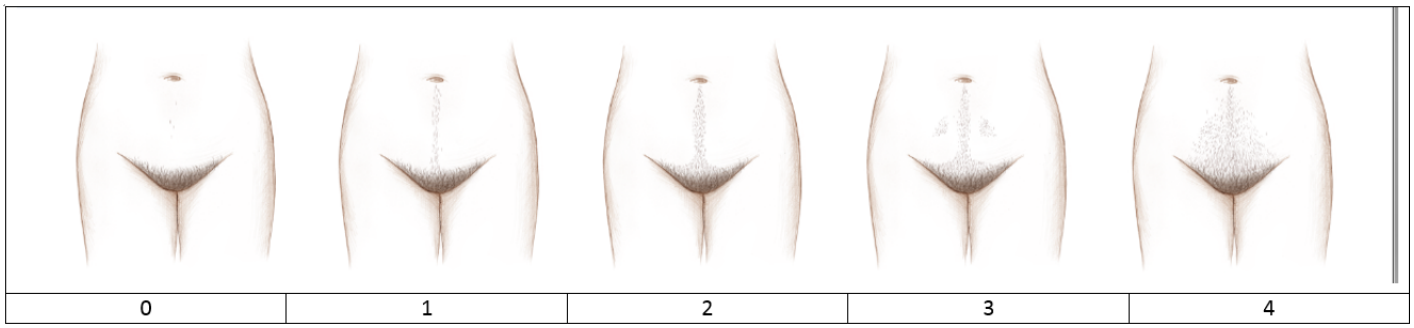
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much coarse or thick hair do you have on your upper abdomen?



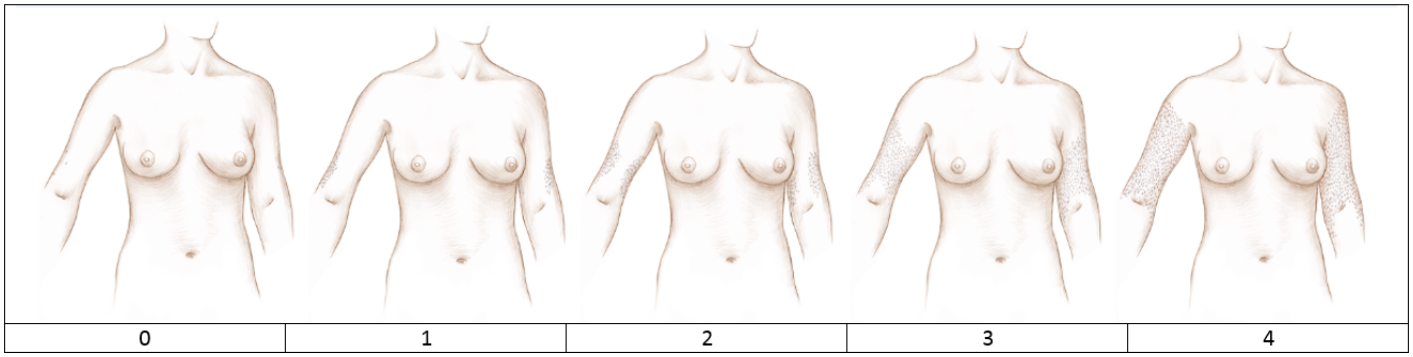
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much coarse or thick hair do you have on your lower abdomen - that is the area from your belly button to your pubic area?



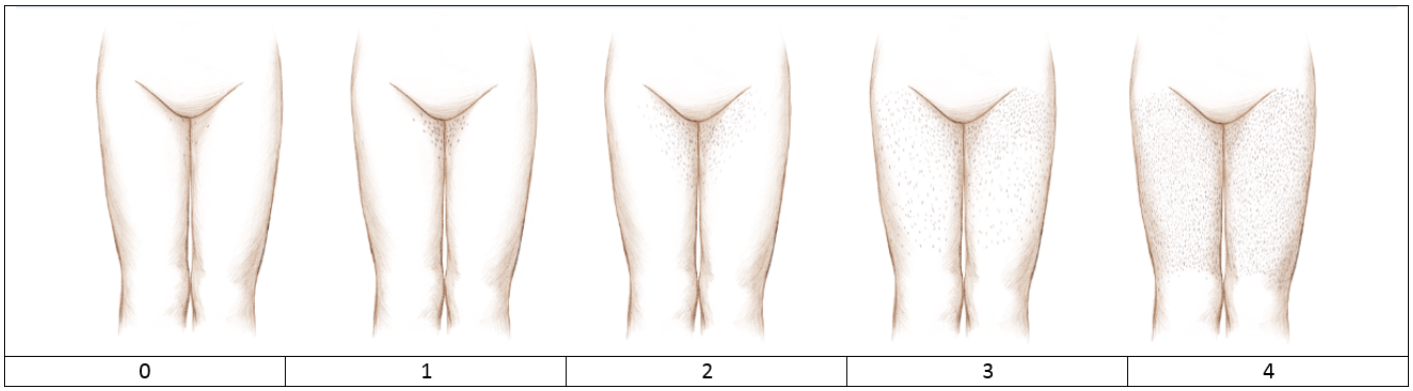
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much coarse or thick hair do you have on your upper arms?



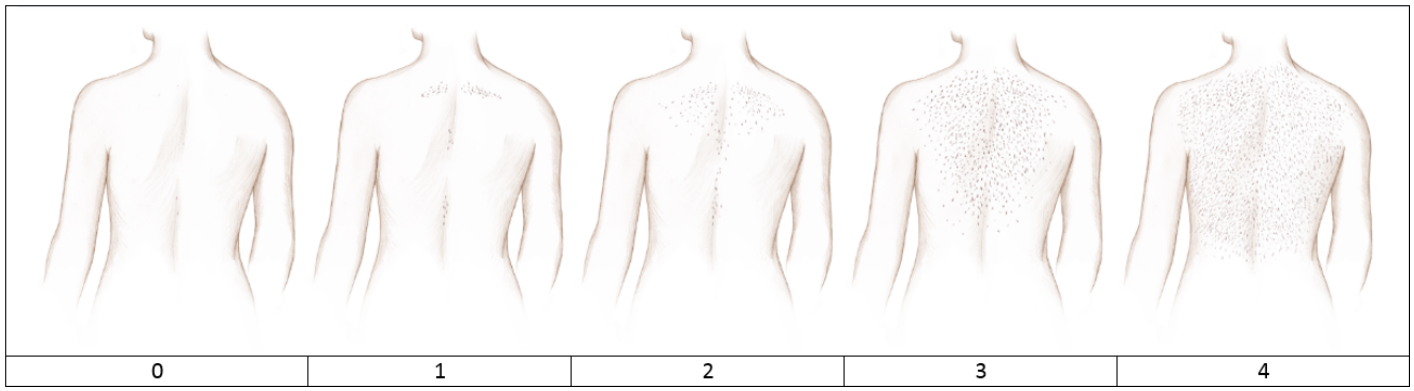
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much thick or coarse hair do you have on your thighs?



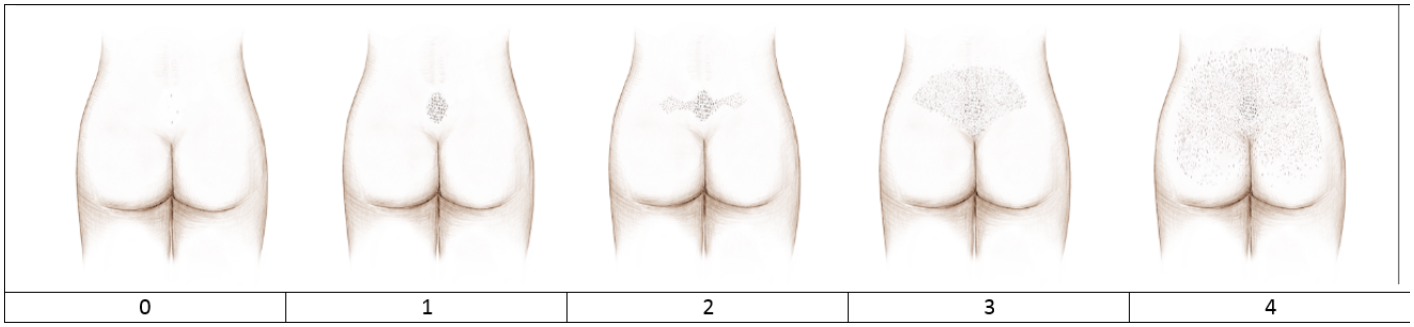
◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

How much coarse or thick hair do you have on your back?



◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

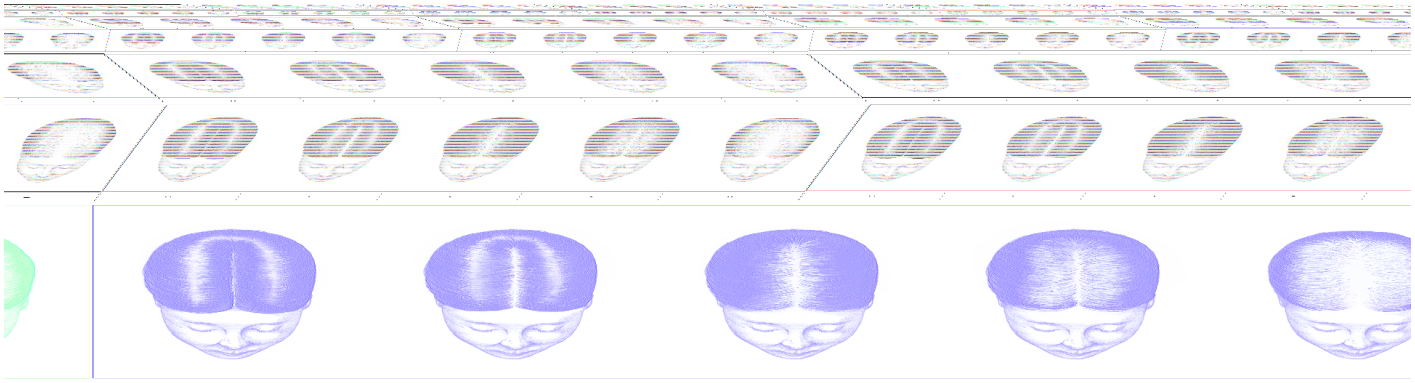
How much coarse or thick hair do you have on your buttocks?



◯ 0 No thick hairs
◯ 1 Few scattered thick hairs
◯ 2 Several scattered thick hairs
◯ 3 Moderate amount of thick hairs
◯ 4 A lot of hair

Scalp Hair

Using the images below, how would you rate your current scalp hair thickness? You can use the images as a guide, but your own hair pattern may be slightly different.



◯ 0 Thick and full hair
◯ 1 Slightly reduced hair with widening part
◯ 2 Reduced hair with widening part and some scalp showing
◯ 3 Significantly reduced hair and more scalp showing
◯ 4 Scalp mostly visible

Do you feel that your hair is thinning faster than other women your age?

◯ Yes
◯ No

At what age do you think your hair started to thin out?

_____

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Date health, medicine, and supplement use form was submitted:

_____

Polycystic Ovary Syndrome

Polycystic Ovary Syndrome is a health condition involving irregular periods, excess testosterone, increased acne, body and facial hair, and many small cysts in the ovaries. Some women also experience hair loss on the scalp. Has a doctor ever diagnosed you with Polycystic Ovary Syndrome or PCOS?

◯ Yes
◯ No

Do you think you might have PCOS?

◯ Yes
◯ No

How were you diagnosed with PCOS?
(Check all that apply)

☐ Irregular periods
☐ Ultrasound
☐ Blood tests, such as testosterone
☐ Other

If Other, please describe:

At what age were you first diagnosed with PCOS?

_____
(years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Who first diagnosed you with PCOS?
(Choose one)

◯ General practitioner
◯ Ob/Gyn
◯ Endocrinologist
◯ Infertility specialist
◯ Pediatrician
◯ Dermatologist
◯ Other

If Other, who diagnosed you with PCOS?

When did you first think you may have PCOS?

_____
(Age in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

What was your first symptom of PCOS?
(Choose one)

◯ Acne
◯ Increased facial or body hair
◯ Irregular periods
◯ Don't Know

What other symptoms of PCOS have you ever had?
(Check all that apply)

☐ Acne
☐ Increased facial or body hair
☐ Irregular periods
☐ Hair loss at the scalp
☐ Infertility
☐ Other

If Other, please describe other PCOS symptoms you have ever had:

Have you ever taken any vitamins, supplements, or herbal remedies designed to specifically treat PCOS?

◯ Yes
◯ No

Do you currently take a multivitamin designed for PCOS?

◯ Yes
◯ No

What brand of multivitamin designed for PCOS do you take? Please write the name:

Do you currently take any dietary supplements to help with PCOS symptoms?

◯ Yes
◯ No

Which dietary supplements to help with PCOS symptoms do you take?
(Check all that apply)

☐ Fish oil capsules (omega-3-fatty acids)
☐ Myoinositol
☐ Protein shakes/supplements
☐ Probiotics
☐ Prebiotics
☐ Other

If Other, please list all other dietary supplements you take to help with PCOS symptoms in the box:

Do you currently take any herbal remedies to help with PCOS related symptoms?

◯ Yes
◯ No

Which herbal remedies do you take to help with PCOS related symptoms?
(Check all that apply)

☐ Echinacea
☐ Ginko Biloba
☐ St. Johns Wort
☐ Kava Kava
☐ Other

If Other, please list all other herbal remedies you take to help with PCOS symptoms in the box:

Do you drink Spearmint tea to help with PCOS?

◯ Yes
◯ No

Have you ever taken any medicines to treat PCOS?

◯ Yes
◯ No

What medicines have you ever taken to treat PCOS?
(Check all that apply)

☐ Hormonal contraceptives to regulate menses (oral contraceptive pills)
☐ Metformin
☐ Spironolactone
☐ Other

If Other, please list all other medicines you have ever taken to treat PCOS in the box:

Are you currently taking any medicines to treat your PCOS?

◯ Yes
◯ No

What medicines for PCOS are you currently taking?
(Check all that apply)

☐ Hormonal contraceptives to regulate menses (oral contraceptive pills)
☐ Metformin
☐ Spironolactone
☐ Other

If Other, please list all other medicines for PCOS you are currently taking in the box:

Have any of your female relatives been diagnosed with PCOS (polycystic ovary syndrome)? For this question, we only want to know about those related to you by blood.

◯ Yes
◯ No
◯ Don't Know

Which of your female blood relatives have been diagnosed with PCOS?
(Check all that apply)

☐ Grandmother
☐ Mother
☐ Aunt
☐ Cousin
☐ Sister
☐ Niece
☐ Daughter
☐ Other
☐ Don't Know

What other female blood relatives have been diagnosed with PCOS?

Has a doctor or other health provider ever told you about health problems that are linked with PCOS?

◯ Yes
◯ No

From what you know, how does PCOS influence a woman's future health?
(Check all that apply)

- ☐ Makes it more difficult to get pregnant
- ☐ Increases the risk of uterine lining overgrowth
- ☐ Increases the chances of obesity
- ☐ Increases the risk of diabetes
- ☐ Increases the risk of cholesterol
- ☐ Increases the risk of heart disease
- ☐ Other
- ☐ Don't know
- ☐ None of the above

Date PCOS form was submitted:

_____

Reproductive Health Questions

Infertility

Have you ever tried for six months or more to become pregnant without becoming pregnant?

◯ Yes
◯ No

Thinking about the first time you experienced this, how old were you?

_____
(Enter in years)

☐ Don't know

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

How long did you try for?

◯ 5 months or less
◯ 6 months - 12 months
◯ 1 year or more

Have you ever visited a doctor because of difficulty becoming pregnant?

◯ Yes
◯ No

Did the doctor test you for your difficulties in becoming pregnant?

◯ Yes
◯ No
◯ Don't Know

Did the doctor say the difficulties were related to a problem with your Fallopian tubes?

◯ Yes
◯ No
◯ Don't Know

Did the doctor say the difficulties related to problems with your ovulation?

◯ Yes
◯ No
◯ Don't Know

Did the doctor say the difficulties were related to your thyroid hormone OR your prolactin hormone?

◯ Yes
◯ No
◯ Don't Know

Did the doctor say the difficulties were related to a problem with your cervix?

◯ Yes
◯ No
◯ Don't Know

Did the doctor test your male partner for your difficulties in becoming pregnant?

◯ Yes
◯ No
◯ Didn't have a partner
◯ Don't Know

Did the doctor say that the difficulties related to your male partner?

◯ Yes
◯ No
◯ Don't Know

Did the doctor say that the difficulties related to something else?

◯ Yes
◯ No

If yes, please type in reason:

Uterine Fibroids

Have you ever been diagnosed with uterine fibroids?

◯ Yes
◯ No

At what age were you first diagnosed with uterine fibroids?

_____
(Enter in years)

☐ Don't Know

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Endometriosis

Have you ever been diagnosed with endometriosis?

◯ Yes
◯ No

At what age were you first diagnosed with endometriosis?

_____
(Enter in years)

☐ Don't Know

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Premature Ovarian Failure / Menopause

Premature ovarian failure occurs when the ovaries stop producing eggs and making estrogen before the age of 40. Have you ever been diagnosed with premature ovarian failure?

◯ Yes
◯ No
◯ Don't Know

At what age were you first diagnosed with premature ovarian failure?

_____
(Enter in years)

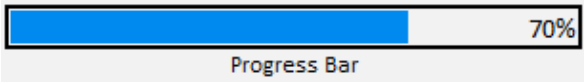
☐ Don't Know

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Date Reproductive Health form was submitted:

_____

General Health Questions



Gastrointestinal disease

Gastroesophageal reflux disease (GERD) is also called heartburn and acid reflux. Have you ever been diagnosed with heartburn or GERD?

◯ Yes
◯ No

At what age were you first diagnosed with heartburn or GERD?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently take any doctor prescribed medicine for heartburn or GERD?

◯ Yes
◯ No

Do you take any over the counter medications for heartburn or GERD?

◯ Yes
◯ No

Eating Disorders

Have you ever had an eating disorder?

◯ Yes
◯ No

If yes, what eating disorders have you been diagnosed with?
(Check all that apply)

☐ Anorexia nervosa
☐ Bulimia
☐ Binge eating

At what age were you first diagnosed with an eating disorder?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently have an eating disorder?

◯ Yes
◯ No

If yes, what eating disorders do you currently have?
(Check all that apply)

☐ Anorexia nervosa
☐ Bulimia
☐ Binge eating

Hypertension

Have you ever been diagnosed with high blood pressure (not during pregnancy)?

◯ Yes
◯ No

At what age were you first diagnosed with high blood pressure?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently take any medicine for your high blood pressure?

◯ Yes
◯ No

High Cholesterol

Have you ever been diagnosed with high cholesterol?

◯ Yes
◯ No

At what age were you first diagnosed with high cholesterol?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently take any medicine for your high cholesterol?

◯ Yes
◯ No

Diabetes

Have you ever been diagnosed with diabetes? Do not include diabetes during pregnancy.

◯ Yes
◯ No

At what age were you first diagnosed with diabetes?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently take any medicine for diabetes?

◯ Yes
◯ No

Do you currently take pills for diabetes?

◯ Yes
◯ No

Do you take insulin injections for diabetes?

◯ Yes
◯ No

Non-alcoholic fatty liver disease

Have you ever been diagnosed with non-alcoholic fatty liver disease?

◯ Yes
◯ No
◯ Don't know

At what age were you first diagnosed with non-alcoholic fatty liver disease?

_____
(Enter in years)

☐ Don't Remember

The age you entered is older than your current age (based on the birth date you entered in an earlier form). Please review your response above.

Thryoid disease

Have you ever been diagnosed with thyroid disease, such as over or underactive thyroid, hypothyroid, hyperthyroid, Graves' disease, Hashimoto's thyroiditis, or autoimmune thyroiditis?

◯ Yes
◯ No
◯ Don't Know

At what age were you first diagnosed with thyroid disease?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently take any medication for thyroid disease?

◯ Yes
◯ No

Excess Prolactin

Have you ever been diagnosed with excess prolactin?

◯ Yes
◯ No
◯ Don't Know

At what age were you first diagnosed with excess prolactin?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Do you currently take any medicine for your excess prolactin?

◯ Yes
◯ No

Sleep Apnea

Have you ever been diagnosed with sleep apnea?

◯ Yes
◯ No

At what age were you first diagnosed with sleep apnea?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Are you currently using a continuous positive airway pressure (CPAP) device for your sleep apnea?

◯ Yes
◯ No

Post Traumatic Stress Disorder

Have you ever been diagnosed with post traumatic stress disorder (PTSD)?

◯ Yes
◯ No

At what age were you first diagnosed with post traumatic stress disorder (PTSD)?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Chronic Fatigue Syndrome

Have you ever been diagnosed with chronic fatigue syndrome?

◯ Yes
◯ No

At what age were you first diagnosed with chronic fatigue syndrome?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Seizure Disorder

Have you ever been diagnosed with seizure disorder?

◯ Yes
◯ No

At what age were you first diagnosed with seizure disorder?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Are you currently taking medicine for seizure disorder?

◯ Yes
◯ No

What is the name of the Seizure Disorder medication that you currently use?

☐ Don't know the name

How often do you take this medicine?

◯ Daily
◯ Daily plus occasionally extra due to symptoms

Depression

Have you ever been diagnosed with depression?

◯ Yes
◯ No

At what age were you first diagnosed with depression?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Have you ever taken any medicine for depression?

◯ Yes
◯ No

What is the name of the medicine for depression that you have taken the longest?

☐ Don't know the name

Are you currently taking any medicine for depression?

◯ Yes
◯ No

What is the name of the medicine for depression that you are currently taking?

☐ Don't know the name

Anxiety/Panic Disorder

Have you ever been diagnosed with anxiety or panic disorder?

◯ Yes
◯ No

At what age were you first diagnosed with anxiety or panic disorder?

_____
(Enter in years)

☐ Don't remember

The age you entered is older than your current age (based on the age you entered in an earlier form). Please review your response above.

Have you ever taken any medicines for anxiety or panic disorder?

◯ Yes
◯ No

What is the name of the medicine for anxiety or panic disorder that you have taken the longest?

☐ Don't know the name

Are you currently taking any medicine for anxiety or panic disorder?

◯ Yes
◯ No

What is the name of the medicine for anxiety or panic disorder that you are currently taking?

☐ Don't know the name

Date General Health form was submitted:

_____

Diet and Lifestyle

The next questions ask about your diet and lifestyle.

A serving of diet soda is 12 ounces (a can). In an average day, how many cans of diet soda do you drink?

◯ None
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 or more

A serving of regular sugar-sweetened soda is 12 ounces (a can). In an average day, how many cans of regular soda do you drink?

◯ None
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 or more

A serving of fruit juice is 4 ounces (half a cup). In an average day, how many servings of fruit juice do you drink?

◯ None
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 or more

In the last month, did you drink any alcoholic beverages?

◯ Yes
◯ No

A serving of alcohol is a 12-oz can of beer, 4 oz glass of wine, or a 1.5 oz shot of liquor. In an average week, how many servings of alcohol did you drink?

_____

In the past month, how many times did you drink 4 or more servings of alcohol in a 4-hour window?

_____

The next questions will ask about your smoking habits.

Have you smoked at least 100 cigarettes in your lifetime?

◯ Yes
◯ No

How often do you now smoke cigarettes?

◯ Every Day
◯ Some days
◯ I do not smoke anymore

Have you ever smoked weed or marijuana?

◯ Yes
◯ No

Do you currently smoke marijuana?

◯ Yes
◯ No

In the past week, how often have you smoked marijuana?

◯ Several times a day
◯ Every Day
◯ 4-6 times per week
◯ 1-3 times per week
◯ Less than 1 time per week

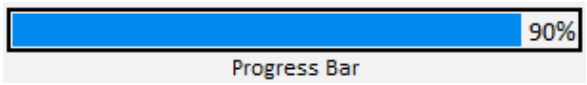
Date Lifestyle and Diet form was submitted:

_____

This form repeats per number of pregnancies reported. We have only included one pregnancy for brevity.

Pregnancy & Birth History

The next several questions ask about your pregnancy history. We want to know about all your pregnancies.



Have you ever been pregnant? Please include live births, stillbirths, miscarriages, induced abortions, and tubal and other ectopic pregnancies.

◯ Yes
◯ No

How many times have you been pregnant? Please include live births, stillbirths, miscarriages, induced abortions, and tubal and other ectopic pregnancies.

◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10
◯ 11
◯ 12
◯ 13
◯ 14
◯ 15

Please start with your first (earliest) pregnancy.

When did your first pregnancy end?
Please enter the year and month.

Year: _____

Month:

◯ January ◯ February
◯ March ◯ April ◯ May
◯ June ◯ July ◯ August
◯ September ◯ October
◯ November ◯ December
◯ Don't remember the month

What was the result of this pregnancy?

◯ Live born child or children
◯ Stillborn
◯ Miscarriage
◯ Abortion
◯ Tubal and other ectopic pregnancy
◯ Other

In this pregnancy, were you carrying a single baby, twins, or three or more babies?

◯ Single baby
◯ Twins
◯ Triplets
◯ Quadruplets or more

Was this pregnancy planned?

◯ Yes
◯ No

How long did it take you to get pregnant?

◯ < 3 months
◯ 3-6 months
◯ 6-12 months
◯ >12 months
◯ Don't Remember

Did you take fertility treatments to conceive this pregnancy?

◯ Yes
◯ No

A typical pregnancy lasts 40 weeks. How many weeks did that pregnancy last?

◯ 0-12 weeks
◯ 13-24 weeks
◯ 25-36 weeks
◯ 37-42 weeks
◯ Don't remember

During this pregnancy did you ever visit a doctor or other health care provider for a check-up for prenatal care?

◯ Yes
◯ No

When was your first prenatal visit?

◯ During the first trimester (First 3 months of pregnancy)
◯ During the 2nd trimester (months 4 to 6 of pregnancy)
◯ During the 3rd trimester (months 7 to 9 of pregnancy)

During this pregnancy, did you have high blood pressure?

◯ Yes
◯ No

Were you diagnosed with high blood pressure before this pregnancy started or were you diagnosed during this pregnancy?

◯ Before this pregnancy
◯ During this pregnancy

During this pregnancy, did a doctor or other health care provider tell you that you had protein in your urine?

◯ Yes
◯ No

During this pregnancy, did you have preeclampsia or pregnancy-induced toxemia?

◯ Yes
◯ No

Gestational diabetes is a type of diabetes that only happens during a pregnancy. During this pregnancy, did you have gestational diabetes?

◯ Yes
◯ No

Did you have vaginal bleeding during this pregnancy?

◯ Yes
◯ No

Did you have anemia or low iron level during this pregnancy?

◯ Yes
◯ No

Did you have placental abruption or separation during this pregnancy?

◯ Yes
◯ No

Placenta previa is a condition where the placenta covers the opening of the birth canal. Did you have placenta previa during this pregnancy?

◯ Yes
◯ No

Did you have a weak or incompetent cervix during this pregnancy?

◯ Yes
◯ No

How was this baby delivered?

◯ C-section
◯ Vaginal delivery

Was this child a boy or girl?

◯ Boy
◯ Girl

What was the birth weight of the baby?
Please select if you are responding in pounds and ounces or in grams. If you don't remember, select Don't Know.

◯ Pounds and ounces
◯ Grams
◯ Don't Know

Pounds:

_____

Ounces:

_____

Grams:

_____

Thinking about your first delivered twin, was this child a boy or girl?

◯ Boy
◯ Girl

How was this baby delivered?

◯ C-section
◯ Vaginal delivery

What was the birth weight of your first delivered twin?
Please select if you are responding in pounds and ounces or in grams. If you don't remember, select Don't Know.

◯ Pounds and ounces
◯ Grams
◯ Don't Know

Pounds:

_____

Ounces:

_____

Grams:

_____

Thinking about your second delivered twin, was this child a boy or girl?

◯ Boy
◯ Girl

How was this baby delivered?

◯ C-section
◯ Vaginal delivery

What was the birth weight of your second delivered twin?
Please select if you are responding in pounds and ounces or in grams. If you don't remember, select Don't Know.

◯ Pounds and ounces
◯ Grams
◯ Don't Know

Pounds:

_____

Ounces:

_____

Grams:

_____

Thinking about your first delivered triplet, was this child a boy or girl?

◯ Boy
◯ Girl

How was this baby delivered?

◯ C-section
◯ Vaginal delivery

What was the birth weight of your first delivered triplet?
Please select if you are responding in pounds and ounces or in grams. If you don't remember, select Don't Know.

◯ Pounds and ounces
◯ Grams
◯ Don't Know

Pounds:

_____

Ounces:

_____

Grams:

_____

Thinking about your second delivered triplet, was this child a boy or girl?

◯ Boy
◯ Girl

How was this baby delivered?

◯ C-section
◯ Vaginal delivery

What was the birth weight of your second delivered triplet?
Please select if you are responding in pounds and ounces or in grams. If you don't remember, select Don't Know.

◯ Pounds and ounces
◯ Grams
◯ Don't Know

Pounds:

_____

Ounces:

_____

Grams:

_____

Thinking about your third delivered triplet, was this child a boy or girl?

◯ Boy
◯ Girl

How was this baby delivered?

◯ C-section
◯ Vaginal delivery

What was the birth weight of your third delivered triplet?
Please select if you are responding in pounds and ounces or in grams. If you don't remember, select Don't Know.

◯ Pounds and ounces
◯ Grams
◯ Don't Know

Pounds:

_____

Ounces:

_____

Grams:

_____

Overall, about how much weight did you gain during this pregnancy?

◯ Less than 25 pounds
◯ 25-34 pounds
◯ 35-54 pounds
◯ 55 pounds or more
◯ I did not gain weight during this pregnancy

Sometimes, babies are smaller than we expect. During this pregnancy, was your baby smaller than expected for his/her gestational age?

◯ Yes
◯ No
◯ Don't Know

Sometimes, babies are larger than we expect. During this pregnancy, was your baby larger than expected for his/her gestational age?

◯ Yes
◯ No
◯ Don't Know

Sometimes, babies don't move as much as we expect. During this pregnancy, did your baby move less than expected in the last trimester of pregnancy?

◯ Yes
◯ No
◯ Don't Know

Did you breastfeed this baby?

◯ Yes
◯ No

What was the longest time you breastfed this baby?
(Choose one)

◯ Less than 1 month
◯ 1-3 months
◯ 4-6 months
◯ 7-12 months
◯ More than 1 year

Sometimes, babies are smaller than we expect. During this pregnancy, were any of your babies smaller than expected for their gestational age?

◯ Yes
◯ No
◯ Don't Know

Sometimes, babies are larger than we expect. During this pregnancy, were any of your babies larger than expected for their gestational age?

◯ Yes
◯ No
◯ Don't Know

Sometimes, babies don't move as much as we expect. During this pregnancy, did any of your babies move less than expected in the last trimester of pregnancy?

◯ Yes
◯ No
◯ Don't Know

Did you breastfeed any of these babies?

◯ Yes
◯ No

What was the longest time you breastfed any of these babies?
(Choose one)

◯ Less than 1 month
◯ 1-3 months
◯ 4-6 months
◯ 7-12 months
◯ More than 1 year

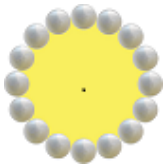
Please write about any other details of your pregnancy that you would like to share:

Date Pregnancy History 1 form was submitted:

_____

END OF SURVEY MODULE 1

Thank you for completing the baseline questionnaire. If you have agreed to be recontacted, we will contact you in the future about follow up surveys.

If you have any questions about the study, please contact the study coordinator by phone [redacted] or at [redacted].

Thank you!