

Fertility questionnaire

Please give your name and the email address:

.....

Please give your date of birth:

dd/mm/yyyy

(US version mm/dd/yyyy)

Please tick all the boxes to indicate agreement with the statements below:

☐

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had any questions answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without consequence or liability.

☐

I understand that my anonymised data, collected during the study, will be used by researchers from the University of Bristol, UK and Carolinas Medical Center, Charlotte, USA.

Please choose from one answer below to indicate your consent to take part in the survey and study, or to leave the survey:

☐

I agree to take part in the survey and study (*If chosen go to A1*)

☐

I don't wish to continue with the survey or study (*If chosen show disqualification message*)

Section A: About you

A1. How would you describe the race or ethnic group of yourself and your natural parents? (tick all that apply)

	Yourself	Your mother	Your father
White			
Black/Caribbean			
Black/African			
Black/other			
Indian			
Pakistani			
Bangladeshi			
Chinese			
Hispanic			
Any other ethnic group

A2. a) Are you currently employed or self-employed?

Yes

No

If no go to A4d

Prefer not to answer

If prefer not to answer go to A4d

If yes:

b) What is your occupation (or job title)?

.....

c) Does your work involve night shifts? *(If you have more than one 'current job' then answer this question for your MAIN job only. Night shifts are a work schedule that involves working through the normal sleeping hours, for instance working through the hours from 12am [midnight] to 6am)*

Never/rarely

Sometimes

Usually

Always

Do not know

Prefer not to answer

d) Do you have a university degree?

Yes

No

A3. a) Do you have a partner?

Yes

No

if no go to A6

Prefer not to answer

If prefer not to say go to A6

If yes

b) Is your partner currently employed or self-employed?

Yes

No

If no go to A5d

Prefer not to say

If prefer not to say go to A5d

If yes:

c) What is their occupation (or job title)?

.....

d). Does your partner have a university degree?

Yes

No

A4. a) What units do you use to measure your weight

☐

Stones

☐

Kilos

☐

Pounds (US)

☐

Prefer not to give my weight (*if ticked go to A7*)

b) What is your current weight?

.....

A5. a) What units do you use to measure your hip size?

☐

cm

☐

inches

☐

Prefer not to give my hip size (*if ticked go to A7ii*)

What size are your hips?

.....

b) What units do you use to measure your waist size?

☐

cm

☐

inches

☐

Prefer not to give my waist size (*if ticked go to A7iii*)

What size is your waist?

.....

c) What units do you use to measure your bust circumference?

☐

cm

☐

inches

☐

Prefer not to give my bust size (*if ticked go to A8*)

What size is your bust circumference?

.....

A6. What units do you use to measure your height?

☐

Feet and inches

☐

Centimeters

☐

Prefer not to give my height (*if ticked go to B1*)

How tall are you?

.....

Section B: Lifestyle

B1. a) Have you ever been a regular smoker?

Yes

No *if no, go to B2*

Prefer not to answer *if prefer not to answer, go to B2*

if yes

b) At what age did you start smoking regularly?

..... years

c) Which of the following have you ever smoked regularly? (tick all that apply)

Cigarettes

Pipe

Cigar

e-cigarette

other

d) Have you now stopped smoking?

Yes

No *If no go to B1g*

Prefer not to answer *If prefer not to answer go to B2*

If yes

e) Please enter the estimated date on which you stopped smoking. If you do not know the month, please just give the year

..... Month (as number mm) Year (as number yyyy)

f) If you smoked cigarettes, how many did you smoke per day?

On weekdays:

On weekend days

If no

g) If you smoke cigarettes, how many do you currently smoke per day?

On weekdays:

On weekend days

B2. Which of the following statements about alcohol best applies to yourself (1 glass = 1 standard bar measure of spirits or 1 small glass of wine or a 1/2 pint of beer or cider):

Never drink alcohol

Very occasionally (less than once a week)

Occasionally (at least once a week)

Drinks 1-2 glasses* nearly every day

Drinks 3-9 glasses* every day

Drinks at least 10 glasses a day

Don't know

B3. a) Compared with other women of your age, would you consider yourself to be:

Much more active

Somewhat more active

About the same

Somewhat less active

Much less active

b) Currently at least once a week do you engage in any regular activity like brisk walking, gardening, housework, jogging, cycling, etc. long enough to work up a sweat?

Yes

No

if no go to section B4

Prefer not to answer

if prefer not to answer go to section B4

If yes

c) How many hours a week:

..... hours

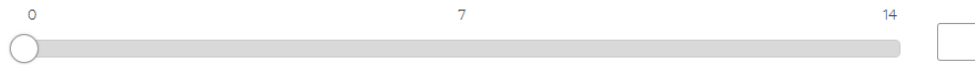
d) How much do you do the following at present?

	More than 7 hours per week	2-6 hours per week	Less than one hour per week	Never
Jogging				
Aerobics				
Keep fit exercises				
Yoga				
Squash				
Tennis/badminton				
Swimming				
Brisk walking				
Weight training				
Cycling				
Other exercise				

.....

-
- B4. a) About how many hours sleep do you get in every 24 hours? (please include naps)
sliding scale from 0 to 14

0 7 14 ☐



- b) Do you have trouble falling asleep at night or do you wake up in the middle of the night?

Never/rarely

Sometimes

Usually

Prefer not to answer

- c) How likely are you to doze off or fall asleep during the daytime when you don't mean to?

Never/rarely

Sometimes

Often

Do not know

Prefer not to answer

All of the time

- d) Do you consider yourself to be?

Definitely a 'morning' person

More a 'morning' than 'evening' person

More an 'evening' than a 'morning' person

Definitely an 'evening' person

Do not know

Prefer not to answer

Section C: General health

- C1. a) Have you ever had diabetes?

Yes

No

Prefer not to answer

if no, go to C2

if prefer not to answer, go to C2

If yes

- b) Have you only had it when you were pregnant?

Not applicable

Yes

No

c) How old were you (in years) when you first developed it?

.....

d) How was/ is your diabetes treated? (please tick all that apply)

Diet and exercise advice

Drugs that you took/ take by mouth

Insulin injections

C2. a) Have you ever had hypertension (high blood pressure)?

Yes

No

if no, go to C3

Prefer not to answer

if prefer not to answer, go to C3

if yes

b) Have you had hypertension only when pregnant?

Not applicable

Yes

No

c) How old were you (in years) when you first developed it?

.....

d) Are you currently taking drugs prescribed by a doctor for high blood pressure?

Yes

No

Prefer not to answer

if prefer not to answer, go to C3

if Yes

e) Please write the name of the drug you are taking for high blood pressure (e.g. Ramipril)

.....

f) What is the dose of the drug? (e.g. 5mg)

.....

g) Please enter the frequency (e.g. twice per day)

.....

C3. a) Are there any problems for which you have regular treatment or medicine?

Yes

No

If no, go to section D

Prefer not to answer

If prefer not to answer, go to section D

If yes

b) Please describe the problem and regular treatment or medicine (include the name of any drug/medicine and the dose and frequency that you take):

Problem 1:

Treatment 1:

Problem 2:

Treatment 2:

Problem 3:

Treatment 3:

Problem 4:

Treatment 4:

Problem 5:

Treatment 5:

Problem 6:

Treatment 6:

Please add any other problems and treatments not covered above:

.....

Section D: Your feelings in the past week

Your feelings in the past week.

D1. I have been able to laugh and see the funny side of things:

As much as I always could

Not quite so much now

Definitely not so much now

Not at all

D2. I have looked forward with enjoyment to things:

As much as I ever did

Rather less than I used to

Definitely less than I used to

Hardly at all

D3. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time

Yes, some of the time

Not very often

Never

D4. I have been anxious or worried for no good reason:

No, not at all
Hardly ever
Yes, sometimes
Yes, often

D5. I have felt scared or panicky for no very good reason:

Yes, quite a lot
Yes, sometimes
No, not much
No, not at all

D6. Things have been getting on top of me:

Yes, most of the time I haven't been able to cope
Yes, sometimes I haven't been coping as well as usual
No, most of the time I have coped quite well
No, I have been coping as well as ever

D7. I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time
Yes, sometimes
Not very often
No, not at all.

D8. I have felt sad or miserable:

Yes, most of the time
Yes, quite often
Not very often
No, not at all

D9. I have been so unhappy that I have been crying:

Yes, most of the time
Yes, quite often
Only occasionally
Never

D10. The thought of harming myself has occurred to me:

Yes, quite often
Sometimes
Hardly ever
Never

D11. I have felt stressed:

Yes, most of the time
Yes, quite often
Not very often
No, not at all

Section E: Previous (or current) pregnancies

E1. a) Are you currently pregnant?

Yes

No *if no, go to E2*

Prefer not to answer *if prefer not to answer, go to E2*

b) How many weeks pregnant are you?

.....

c) How long were you trying before you got pregnant?

Less than 6 months

6-11 months

12 months or more

Pregnancy wasn't planned

Don't remember

d) Have you had excessive vomiting which meant you have had to stay in hospital for some days during this pregnancy?

Yes*

No

*** If yes, please say how many days you were you in hospital for**

.....

e) Have you been told by a doctor or midwife that you have had gestational diabetes during this pregnancy?

Yes

No *if no, go to E1f*

Prefer not to answer *if prefer not to answer, go to E1f*

(If yes) How is your gestational diabetes treated? (please tick all that apply)

Diet and exercise advice

Drugs that you took by mouth

Insulin

f) Have you been told by a doctor or midwife that you have had pre-eclampsia during this pregnancy?

Yes

No *if no, go to E1g*

Prefer not to answer *if prefer not to answer, go to E1g*

(If yes) Have you been admitted to hospital for pre-eclampsia during this pregnancy?

Yes

No

g) Have you been told by a doctor or midwife that you have had gestational hypertension (also called pregnancy related or pregnancy induced hypertension) during this pregnancy?

Yes

No

Prefer not to answer

E2. a) Have you been pregnant in the past?

Yes

No *if no, go to Section F*

Prefer not to answer *if prefer not to answer, go to F*

b) How many times have you been pregnant in the past?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

For each pregnancy please give the following details (if you have had more than 10 pregnancies then please give details for the 10 most recent):

c) How long were you trying before you got pregnant?

Less than 6 months

6-11 months

At least 12 months

Pregnancy wasn't planned

Don't remember

d) Did this result in a live birth?

Yes *if yes go to E2e*

No

Prefer not to answer

If no

Please give the date of the end of this pregnancy.

Go to next pregnancy

e) Please give the date of birth.

f) Please give the units of weight for your baby

pounds ounces



kilograms



g) Please give the birth weight of your baby?

.....

h) Did you have excessive vomiting which meant you had to stay in hospital for some days during this pregnancy?

Yes

No

* If yes, please say how many days you were you in hospital for

.....

i) Were you told by a doctor or midwife that you had gestational diabetes during this pregnancy?

Yes

No

if prefer not to answer, go to E2j

Prefer not to answer

if prefer not to answer, go to E2j

If yes, how was your gestational diabetes treated? (please tick all that apply)

Diet and exercise advice

Drugs that you took by mouth

Insulin

j) Were you told by a doctor or midwife that you had pre-eclampsia during this pregnancy?

Yes

No

if prefer not to answer, go to E2k

Prefer not to answer

if prefer not to answer, go to E2k

If yes,

Did you need to be admitted to hospital for the pre-eclampsia during this pregnancy?

Yes

No

Did your baby need to be delivered early during this pregnancy because of the pre-eclampsia?

Yes

No

k) Were you told by a doctor or midwife that you had gestational hypertension (also called pregnancy related or pregnancy induced hypertension) during this pregnancy?

Yes

No

Prefer not to answer

Section F: Current fertility

F1. a) How old were you when your periods (menstrual bleeds) first started?

I have not had periods *go to F3*
Do not remember
Prefer not to answer
My age when my periods first started was:
.....

b) Have you had a period in the last 3 months?

Yes *if yes, go to F2*
No
Prefer not to answer *if prefer not to answer, go to F2*

If no

c) What is the reason you haven't had a period in the past 3 months?

Irregular periods
Contraceptive injection
Contraceptive implant
Intrauterine contraceptive device (IUD, also known as coil)
Contraceptive tablets
Don't know
Other

F2. a) What was the date of the first day of your last period? (if you cannot remember the exact day please provide the month and year)

Day (as number dd)
Month (as number mm)
Year (as number yyyy)

b) Are your periods regular?

Yes
No
Prefer not to answer *if prefer not to answer go to F2.c*

If yes

How regular are your periods?

Every 24 to 27 days
Every 28 to 30 days
Every 30 or more days
Prefer not to answer

If no

How many periods do you have each year?

1-2

3-6

7-12

More than 12

Prefer not to answer

c) How would you describe your most recent (last six) periods:

	Very	Moderately	Mildly	Not at all
How heavy were your periods?				
How painful were your periods?				

F3. a) Have you ever used the contraceptive pill?

Yes

No

If no go to F4

Prefer not to answer

If prefer not to answer, go to F4

If yes,

b) How old were you (in years) when you first took the contraceptive pill?

.....

c) How many years altogether did you take a contraceptive pill?

For less than 1 year

1-2 years

3-4 years

5 years or more

d) Are you currently using the contraceptive pill?

Yes

No

F4. a) Have you ever gone to a doctor because you thought you were infertile?

Yes

No

If no go to F5

Prefer not to answer

If prefer not to answer, go to F5

If yes,

b) What diagnoses were made? (tick all that apply)

Polycystic ovary syndrome (PCOS)

Other ovarian problem

Endometriosis

Problem with your cervix

Partner has a low sperm count or other problems with sperm
 Overactive thyroid
 Underactive thyroid
 Pelvic inflammatory disease
 Diagnosis not made
 Other (please specify).....

c) Which treatments were given? (tick all that apply)

Hormonal ovarian stimulation (please specify in the box below)
 Other fertility drugs (please specify in the box below)
 Intrauterine insemination (IUI)
 IVF
 Surgery
 Other (please describe in detail)

d) Please specify the drug treatments you were given in as much detail as possible (drug names, dosages, when you took them)?

.....

e) If you had IVF (with or without ICSI), was it performed with:

Own eggs and partner's sperm
 Own eggs and donor sperm
 Donor eggs and partner's sperm
 Donor eggs and donor sperm

F5. a) Have you ever had a D and C (scrape)?

Yes
 No *if no go to F6*
 Don't know *if don't know go to F6*
 Prefer not to answer *if prefer not to answer go to F6*

If yes

b) Why did you have a D and C scrape? (tick all that apply)

Yes No

- i) Heavy periods
- ii) Painful periods
- iii) Fibroids
- iv) Termination
- v) Infertility
- vi) Miscarriage
- vii) Don't know
- viii) Other (please tick and describe)

F6. Have you ever had any of the following sexually transmitted infections? (tick all that apply)

Chlamydia

Gonorrhea
Genital herpes
Syphilis
HIV/AIDS
Human papillomavirus (HPV)
Trichomoniasis
Other (please specify)

F7. a) What is your main reason for using OvuSense?

I have been trying to get pregnant and have not been able to
I have reduced fertility and it might help
I am trying to avoid becoming pregnant
I am just interested in monitoring my cycles
Other

If you are trying to get pregnant, then

b) Are you using any treatments to help you conceive at the moment?

Yes
No
Prefer not to answer

If yes

c) Which treatments have you been given? (tick all that apply)

Hormonal ovarian stimulation (please specify in the box below)
Other fertility drugs (please specify in the box below)
Intrauterine insemination (IUI)
IVF (with or without ICSI)
Surgery
Supplements of homeopathic remedies (e.g. Inositol)
None
Prefer not to answer
Other (please describe in detail)

d) Please specify the drug treatments you have been given in as much detail as possible (drug names, dosages, when you took them)?

.....
.....
.....

e) If you had IVF (with or without ICSI), was it performed with:

Own eggs and partner's sperm
Own eggs and donor sperm
Donor eggs and partner's sperm
Donor eggs and donor sperm

VERY MANY THANKS FOR ALL YOUR HELP

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