Fibroid Growth Study

FGS FORM 101
VERSION: 100802
DATA ENTRY INTL.: _____
PARTICIPANT ID: FGS-_____

Initial Medical Questionnaire
(for the first visit)

Participant ID: **FGS-** | | | |

Interviewer ID: | | | |

Date of Interview: | | | | (MONTH / DAY / YEAR)

Length of Interview: | | | **Minutes**

No. of Sessions: | |

Outcome Code: | |

This work was supported by NIH grant #MO1RR00046, NIEHS contracts #N01-ES-95446 and #273-01-C-0157.
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1. Record each medication brought to the appointment (including prescription, over the counter, vitamins and supplements and herbal remedies).

	What is this medication?	What dose do you take?	How often do you take the medication?	How long have you been taking this?
1a.				
1b.				
1c.				
1d.				
1e.				
1f.				
1g.				
1h.				
1i.				

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2. Are there other medications that you take on a regular basis, but did not bring with you? This includes prescription, over-the-counter, vitamins and supplements and herbal remedies.

Yes ……..1
No ……..2
Refused ……..8
Don't know ……..9

IF YES:

	What is this medication?	Dosage Taken?	How often do you take the medication?	How long have you been taking this?
2a.				
2b.				
2c.				
2d.				
2e.				
2f.				
2g.				
2h.				
2i.				

Now I am going to ask you about recent use of some common medications.

3. In the last 30 days, have you taken aspirin?

Yes ……..1
No ……..2
Refused ……..8
Don't know ……..9

IF YES:

3a. How many do you usually take at a time? | | | **# taken**

3b. How often did you take aspirin in the last 30 days? _____ **frequency**

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4. In the last 30 days, have you taken acetaminophen or Tylenol-type medicine?

Yes ……..**1**
No ……..**2**
Refused ……..**8**
Don't know ……..**9**

IF YES:

4a. How many do you usually take at a time? [ ][ ] **# taken**

4b. How often did you take Tylenol or Tylenol-type medications in the last 30 days? _____ **frequency**

5. In the last 30 days, have you taken anti-inflammatory drugs like Advil or Motrin?

Yes ……..**1**
No ……..**2**
Refused ……..**8**
Don't know ……..**9**

IF YES:

5a. How many do you usually take at a time? [ ][ ] **# taken**

5b. How often did you take Advil or Motrin-like drugs in the last 30 days? _____ **frequency**

6. In the last 30 days, have you taken cold, sinus, or allergy pills (like Contac)?

Yes ……..**1**
No ……..**2**
Refused ……..**8**
Don't know ……..**9**

IF YES:

6a. How many do you usually take at a time? [ ][ ] **# taken**

6b. How often did you take cold, sinus or allergy drugs in the last 30 days? _____ **frequency**

Now I am going to ask you about hormone - type medications, such as birth control.

7. Have you ever used birth control pills?

Yes ……..**1**
No ……..**2**
Refused ……..**8**
Don't know ……..**9**

IF YES:

7a. Are you currently taking birth control pills for any reason?

Yes ……..**1**
No ……..**2**
Refused ……..**8**
Don't know ……..**9**

7b. How old were you when you started using birth control pills, whether or not it was to prevent pregnancy? [ ][ ] **Age**

7c. How many years or month have you taken birth control pills? This includes the total time for your whole life?

	Years	**or**	**Months**

8. Have you tried any alternative methods to treat your fibroids such as:

8a. acupuncture?

Yes	**……..1**
No	**……..2**
Refused	**……..8**
Don't know	**……..9**

8b. chiropractic services?

Yes	**……..1**
No	**……..2**
Refused	**……..7**
Don't know	**……..8**

8c. progesterone cream?

Yes	**……..1**
No	**……..2**
Refused	**……..8**
Don't know	**……..9**

IF YES

8d. What dose of the progesterone cream do you use?

_____

8e. herbal remedies?

Yes	**……..1**
No	**……..2**
Refused	**……..8**
Don't know	**……..9**

IF YES

8f. What type(s) of herbal remedies have you used?

_____

9. Are there other practices you have tried in the past month for your fibroids?

Yes	**……..1**
No	**……..2**
Refused	**……..8**
Don't know	**……..9**

9a. What were those practices?

Practice	**Description**

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Now I would like to as you about some medical procedures or conditions you may have had.

10. Have you ever had a tubal ligation, (your tubes tied)? (This is a surgical procedure that is done so that you wouldn't be able to become pregnant again.)
Yes ……1
No ……2
Refused ……8
Don't know ……9

11. In what year did you have a tubal ligation? [ ][ ][ ][ ] **Year**

IF DON'T KNOW

11a. How old were you when you had a tubal ligation? [ ][ ] **Age**

12. Have you ever had a D & C?
Yes ……1
No ……2
Refused ……8
Don't know ……9

IF YES

13. What was the date of your last D & C? **(IF DON'T KNOW ASK 13a.)** [ ][ ][ ][ ] **Year**

13a. How old were you when you had the last D & C? [ ][ ] **Age**

13b. How many times, in total have you had a D & C? [ ][ ] **# of Times**

14. Have you ever had any surgery that involves the reproductive tract, other than diagnostic laparoscopy, D & C, C-section or tubal ligation?
Yes ……1
No ……2
Refused ……8
Don't know ……9

15. Have you ever had ovarian cysts?
Yes ……1
No ……2
Refused ……8
Don't know ……9

IF YES

16. When was the last time? [ ][ ]
Month **Year**

IF YES

17. Have you ever had surgery to remove ovarian cysts?
Yes ……1
No ……2
Refused ……8
Don't know ……9

IF YES TO 17

18. When was the last time? [ ][ ]
Month **Year**

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19. Have either of your ovaries been removed?

Yes	**……..1**
No	**……..2**
Refused	**……..8**
Don't know	**……..9**

IF YES

20. When were they removed?

Month	**Year**

If participant answered YES to #14, 15 or 19, proceed to QUESTION 21. Otherwise go to QUESTION 31.

21. Have you ever had an MRI that looked at your pelvis or a pelvic ultrasound or sonogram?

Yes	**……..1**
No	**……..2**
Refused	**……..8**
Don't know	**……..9**

IF YES

22. Where was this procedure performed?

UNC Hospital	**……..1**
Duke Hospital	**……..2**
Other Hospital	**……..3**

23. When did you have the last MRI or sonogram?

Month	**Year**

NOTE TO NURSE: **If procedure was performed at UNC or DUKE, ask patient to sign a release form for medical records.**

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If fibroids noted in #26, ASK 30 and 31

	24. What month and year was the first / next surgery?	25. What was the reason for the surgery? What medical problems and what were your primary symptoms?	26. What did your doctor think was causing it?	27. What type of surgery was done?	28. Did you take a GnRH analog medication like Lupron before the surgery? It would have been prescribed to shrink the uterus or decrease bleeding before surgery.	29. What did they find from the surgery? [PAUSE] Did they notice any uterine fibroids? [PAUSE] Endometriosis? [PAUSE] Adenomyosis? [PAUSE] Y N DK	30. How many fibroids did they find?	31. How big was the largest one?
01	___ ___ / _____ MM / YYYY	Bleeding 1 Pelvic pain 2 Infertility 3 Other 4 SPECIFY:	Uterine fibroids 1 Endometriosis 2 Other 3 SPECIFY:	Laparoscopic myomectomy 01 Abdominal myomectomy 02 Hysteroscopic resection 03 Other 04 SPECIFY:	Yes 01 No 02 Don't Know 08	Uterine fibroids 1 2 8 Endometriosis 1 2 8 Adenomyosis 1 2 8 Endometrial polyps 1 2 8 Nabothian cyst 1 2 8 Chronic infection / Cervical - inflammation 1 2 8 Other 1 2 8 SPECIFY:	ONE 1 TWO 2 MANY (enter # below) | | | |	_____._____
02	___ ___ / _____ MM / YYYY	Bleeding 1 Pelvic pain 2 Infertility 3 Other 4 SPECIFY:	Uterine fibroids 1 Endometriosis 2 Other 3 SPECIFY:	Laparoscopic myomectomy 01 Abdominal myomectomy 02 Hysteroscopic resection 03 Other 04 SPECIFY:	Yes 01 No 02 Don't Know 08	Uterine fibroids 1 2 8 Endometriosis 1 2 8 Adenomyosis 1 2 8 Endometrial polyps 1 2 8 Nabothian cyst 1 2 8 Chronic infection / Cervical - inflammation 1 2 8 Other 1 2 8 SPECIFY:	ONE 1 TWO 2 MANY (enter # below) | | | |	_____._____
03	___ ___ / _____ MM / YYYY	Bleeding 1 Pelvic pain 2 Infertility 3 Other 4 SPECIFY:	Uterine fibroids 1 Endometriosis 2 Other 3 SPECIFY:	Laparoscopic myomectomy 01 Abdominal myomectomy 02 Hysteroscopic resection 03 Other 04 SPECIFY:	Yes 01 No 02 Don't Know 08	Uterine fibroids 1 2 8 Endometriosis 1 2 8 Adenomyosis 1 2 8 Endometrial polyps 1 2 8 Nabothian cyst 1 2 8 Chronic infection / Cervical - inflammation 1 2 8 Other 1 2 8 SPECIFY:	ONE 1 TWO 2 MANY (enter # below) | | | |	_____._____

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	32. Have you ever had any of the following conditions? Check either **NO** or **YES** for each condition. For each **YES** answer 40 and 41.	NO (2)	YES (1)	33. If **YES**, how old were you when you first were diagnosed? **AGE**	34. Did you take any prescription MEDICINE for this condition? NO (2)	YES (1)
a.	Abnormal pap smear		If YES →	**FIRST**		
b.	Hepatitis		If YES →			
c.	High blood pressure, not pregnancy induced		If YES →			
d.	High cholesterol		If YES →			
e.	Anemia		If YES →	**FIRST** **LAST**		
f.	Thyroid Condition		If YES →			
g.	Diabetes, high blood sugar or "sugar" not pregnancy induced		If YES →			
h.	Appendicitis		If YES →	**Age when surgery was conducted**		
I.	Urinary tract infection		If YES →	**FIRST** **LAST**		
j.	Keyloid formation (excessive scarring)		If YES →			
k.	Genital herpes		If YES →			
l.	Gonorrhea, "clap" or "drip"		If YES →			
m.	Chlamydia or "drip"		If YES →			
n.	Syphilis or "syph"		If YES →			
o.	Other sexually transmitted diseases **SPECIFY:**		If YES →			

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	35. Have you ever had any of the following conditions? Check either **NO** or **YES** for each condition. For each **YES** answer 40 and 41.	NO (2)	YES (1)	36. If **YES**, how old were you when you were first diagnosed? AGE	37. Did you take any prescription MEDICINE for this condition? NO (2)	YES (1)
p.	Arthritis		If YES →			
q.	Severe headaches, such as migraines		If YES →			
r.	Cold sores (fever sores or fever blisters)		If YES →			
s.	Canker sores (mouth sores or mouth ulcers)		If YES →			

38. Has a doctor or health professional ever told you that you had cancer?

Yes **…….1**
No **…….2**
Refused …….8
Don't know …….9

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	39.	40.	41.		42.		43.	
	What type of cancer(s) have you had? **List Type Below**	**How old were you when you were first diagnosed? AGE**	**Did you have chemotherapy?** **NO (2)**	**YES (1)**	**Did you have radiation therapy?** **NO (2)**	**YES (1)**	**Did you have surgery?** **NO (2)**	**YES (1)**
a.								
b.								

44. Do you have a family history of skin leiomyoma?

Yes	**…….1**
No	**…….2**
Refused	**…….8**
Don't know	**…….9**

IF YES: What relative(s)? _____

_____

45. Do you have a family history of kidney cancer?

Yes	**…….1**
No	**…….2**
Refused	**…….8**
Don't know	**…….9**

IF YES: What relative? _____

_____

46. Do you have a family history of uterine fibroids?

Yes	**…….1**
No	**…….2**
Refused	**…….8**
Don't know	**…….9**

IF YES: What relative? _____

_____