## Menstrual changes post COVID 19 vaccine – Initial questionnaire

1. **Personal Information**

First name: _____ Surname:_____

Date of Birth: _____

Phone number:_____ Email:_____ (both mandatory)

Date of questionnaire:_____

Details of pregnancies and births:

Have you ever been pregnant? Yes/no

If yes, please fill the below details as much as possible:

| **Pregnancy number** | Outcome (vaginal birth / caesarean section / miscarriage / termination) | Gestation (pregnancy length in weeks) |
|---|---|---|
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Have you been diagnosed with COVID 19 infection in the past 3 months? Yes/no

Have you been diagnosed with any of the following gynecological problems? (select all that apply)

1. Uterine fibroids
2. Ovarian cysts
3. Polycystic ovaries or polycystic ovarian syndrome
4. Endometriosis
5. Recurrent pelvic infection
6. Other: _____

Have you been diagnosed with any of the following medical conditions that can affect menstruation? (select all that apply)

1. Bleeding disorders (such as Von Willebrand Disease)
2. Hypothyroidism (underactive thyroid) or Hyperthyroidism (overactive thyroid)
3. Prolactinoma/tumour in pituitary gland
4. Other: _____

Please list your regular medications: _____

**Menstruation**

How old were you when you had your first menstrual period?
_____years

**In the last 3 months:**

**Have you had periods in the last 3 months? Yes/no**

**If yes**

Do you have a record of your period dates (for example in a period tracker App or diary? Yes/No)

If yes,

Using your records, please complete the details of your last 3 menstrual periods

First day of menstrual period: _____ Last day of menstrual period:_____ (or still bleeding)

First day of menstrual period:_____ Last day of menstrual period:_____

First day of menstrual period: _____ Last day of menstrual period:_____

If no

How many days did your period last on average (including spotting)?
_____

Are the intervals between your periods regular? (Counting from first day of one period to the first day of the next period) yes / no. (within 2-3 days each cycle)

If regular, what was your cycle length (the number of days between the first day of one period and the first day of the next period)? _____

If your periods were irregular, what was the shortest duration between 2 periods?
_____

What was the longest duration between 2 periods? _____

**Amount of bleeding**: What would most appropriately describe the amount of bleeding on your heaviest days:

Spotting ___ Light_____ Moderate_____ Heavy_____

How many pads, tampons or menstrual cup do you change on average on the days of heavy bleeding? _____

Do you experience any bleeding between your periods? Yes/No

If yes, how often did you experience any bleeding between your periods?

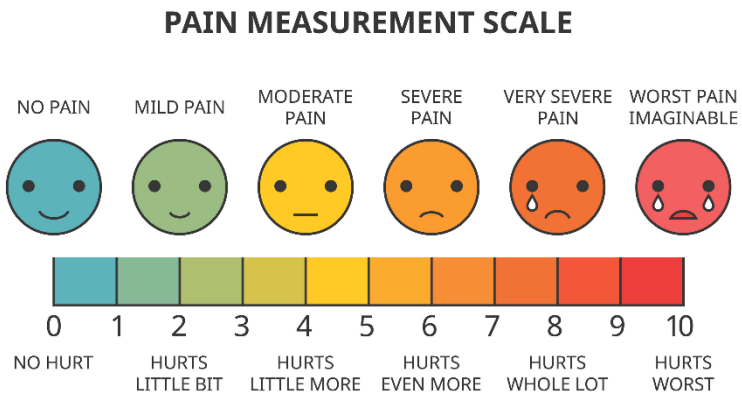
For how many days did you have bleeding between your periods?

Is the bleeding pattern in the last 3 months typical of your periods normally? Y/N

If No, please expand _____

Pain: Do you suffer from any pain during your periods? Yes / No

If yes, what is the intensity of your worst period pain:




If you do experience significant period pain, do you tend to lose days of work or have restriction in other activities due to the pain: yes / no

**Hormonal treatment**

Are you taking/using any hormonal treatment to prevent pregnancy or for any other reason? Yes / No

Pills (please enter name) _____

If you are taking pills, do you connect packs (ie without bleeding between packs / skipping sugar pills to skip periods) yes / no

Hormonal IUD (eg. Mirena or Kyleena IUD) yes/no

Implanon yes/no

Non-hormonal intrauterine device (eg. Copper IUD) yes/no

Other (eg Depot Provera) Please describe: _____

Stress and anxiety assessment

| Over the last 3 months, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | | | | |
| 2. Not being able to stop or control worrying | | | | |
| 3. Worrying too much about different things | | | | |
| 4. Trouble relaxing | | | | |
| 5. Being so restless that it is hard to sit still | | | | |
| 6. Becoming easily annoyed or irritable | | | | |
| 7. Feeling afraid as if something awful might happen | | | | |

In the last 3 months how often have you:

| | never | almost never | sometimes | fairly often | very often |
|---|---|---|---|---|---|
| 1. Been upset because of something that happened unexpectedly? | | | | | |
| 2. Felt that you were unable to control the important things in your life? | | | | | |
| 3. Felt nervous and stressed? | | | | | |
| 4. Felt confident about your ability to handle your personal problems? | | | | | |
| 5. Felt that things were going your way? | | | | | |
| 6. Found that you could not cope with all the things that you had to do? | | | | | |
| 7. Been able to control irritations in your life? | | | | | |
| 8. Felt that you were on top of things? | | | | | |
| 9. Been angered because of things that happened that were outside of your control? | | | | | |
| 10. Felt difficulties were piling up so high that you could not overcome | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| them? | | | | | |

**Vaccine**

Are you having or have you had your first COVID 19 vaccination today Yes/No

If not, do you have a booked date? Yes/No If yes, what is the date?_____

_____

What type of vaccine did you or will you receive (if you know)?

Pfizer

AstraZeneca

Moderna

Novavax