

# The Relationship Between Endometriosis and Female Sexual Function:

## Part 1 — To Be Completed Prior to Surgery

DATE:  /  / 

This study is being conducted to gather scientific data on the impact of endometriosis on women's quality of life and sexual function. The information collected will be used only in aggregated form for scientific purposes. All data will be processed anonymously.

### GENERAL INFORMATION

Age: Weight:  kg      Height:  cmChildren: ☐ Yes (number: ) ☐ NoTotal number of pregnancies: Do you work night shifts ( $\geq 3$  night shifts per month) ☐ Yes ☐ NoDo you have a steady sexual partner (within the last 3 months) ☐ Yes ☐ No

Duration of symptoms:

☐  $< 1$  year      ☐ 1–5 years  
☐  $\geq 5$  years

Chronic conditions:

Medications taken daily:

Alcohol use:

☐ Do not drink      ☐ Rarely ( $\leq 1$  time per month)  
☐ Regularly (1–2 times per week)      ☐ Frequently ( $\geq 3$  times per week)
Physical activity ( $\geq 30$  minutes):
☐ Not regular      ☐ 1–2 times per week  
☐ 3–4 times per week      ☐  $\geq 5$  times per week

Smoking:

☐ Non-smoker      ☐ Currently smokes  
☐ Former smoker

Hormonal contraception:

☐ Never used      ☐ Used previously  
☐ Currently using      ☐ Type: 

Intensity of endometriosis-related pain

0 – no pain; 10 – worst pain possible

During menstruation:

|                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

☐ No menstruation

Outside of menstruation:

|                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Symptoms associated with endometriosis (check all that apply):

|                                                               |                                                                                         |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Heavy menstrual bleeding             | <input type="checkbox"/> Severe pain during menstruation that prevents daily activities |
| <input type="checkbox"/> Prolonged menstruation ( $> 7$ days) | <input type="checkbox"/> Irregular menstruation                                         |
| <input type="checkbox"/> Pain during intercourse              | <input type="checkbox"/> Pain during bowel movements                                    |
| <input type="checkbox"/> Pain during urination                | <input type="checkbox"/> Chronic pelvic pain                                            |
| <input type="checkbox"/> Infertility                          | <input type="checkbox"/> Other: <input type="text"/>                                    |