Please fill in the questionnaire and send it back to us using the enclosed pre-paid envelope. In this questionnaire we refer to the symptoms you had a year ago as your “heavy menstrual bleeding symptoms”. Some women will have the same symptoms that they had a year ago, whilst others may not have any symptoms now. Some women might even have different symptoms now compared with a year ago.

Whatever your situation, the information you provide on the questionnaires is valuable and we would very much like you to complete the questionnaire, even if your symptoms have gone away.

Thank you very much for your help.

Q.1 Please record the date on which you are completing this questionnaire (day, month and year)

Q.2 Please confirm your date of birth (day, month and year)

First we would like you to think about your diagnosis and any treatment you have had in the last year.

Please indicate your answers by ticking (√) the box.

Q.3 In the last year what treatment(s) if any, did you have for heavy menstrual bleeding?

Please tick all that apply.

☐ No treatment
☐ Oral medication (including the pill)
☐ From hospital
☐ From GP or Family Planning Clinic
☐ Intrauterine system (for example Mirena)
☐ From hospital
☐ From GP or Family Planning Clinic
☐ Endometrial ablation (treatment to remove the lining of uterus or womb)
☐ Hysterectomy
☐ Myomectomy (for fibroids)
☐ Uterine artery embolisation
☐ Other treatment
☐ I don’t know what treatment I had
Q.4 What did the hospital doctor(s) say was causing your heavy menstrual bleeding? Please tick all that apply.
- Hormonal imbalance
- Polyps of the lining of the womb
- No obvious cause
- Other cause
- Endometriosis
- Uterine fibroids
- Don’t know

Q.5 In the last year how many times have you seen your GP about heavy menstrual bleeding?
- None
- Don’t know
- 1-2 times
- 3-4 times
- More than 4 times

Q.6 In the last year, have you been pregnant?
- Yes
- No
- Not sure
- I do not want to answer this question

The next few questions are about your heavy menstrual bleeding symptoms and your health generally.

Q.7 Overall, how would you say your health is?
- Excellent
- Very good
- Good
- Fair
- Poor

Q.8 Overall, how are your heavy menstrual bleeding symptoms now compared with 1 year ago?
- Much better
- A little better
- About the same
- A little worse
- Much worse

Q.9 Do you have any new symptoms now that you didn’t have 1 year ago? Please tick all that apply.
- I do not have any new symptoms
- Pelvic pain
- Breast tenderness
- Bladder problems
- Mood changes
- Wound problems
- Irregular bleeding
- Hot flushes
- Light periods
- Other

Q.10 During the last 3 months, how much pain did you experience during your periods?
- No pain
- Very mild pain
- Mild pain
- Moderate pain
- Severe pain
- Very severe pain
- I haven’t had a period in the last 3 months
Q.11 If you were to spend the next 5 years with your heavy menstrual bleeding symptoms the way they are now, how would you feel about that?

Delighted ☐  Pleased ☐  Mostly satisfied ☐  Mixed – about equally satisfied and dissatisfied ☐  Mostly dissatisfied ☐  Unhappy ☐  Terrible ☐

Next we would like you to think overall about your experience at the hospital during the last year.

Q.12 How much information about your heavy menstrual bleeding or treatment was given to you at the hospital?

☐ Not enough  ☐ The right amount  ☐ Too much
☐ I did not receive any information from the hospital

Q.13 How satisfied or dissatisfied were you with the information you received from the hospital?

☐ Very satisfied  ☐ Somewhat satisfied  ☐ Somewhat dissatisfied  ☐ Very Dissatisfied
☐ I did not receive any information from the hospital

Q.14 Were you involved as much as you wanted to be in decisions about your care and treatment?

☐ Yes definitely  ☐ Yes, to some extent  ☐ No

Q.15 If you had important questions to ask the hospital doctor(s), did you get answers that you could understand?

☐ Yes definitely  ☐ Yes, to some extent  ☐ No

Q.16 Did the hospital doctor(s) listen to what you had to say?

☐ Yes definitely  ☐ Yes, to some extent  ☐ No

Q.17 Did you feel that the hospital doctor(s) understood what you wanted?

☐ Yes definitely  ☐ Yes, to some extent  ☐ No

Q.18 Were you given enough privacy when discussing your condition or treatment?

☐ Yes definitely  ☐ Yes, to some extent  ☐ No

Q.19 Did you feel that you were treated with respect and dignity while you were in the hospital?

☐ Yes always  ☐ Yes, sometimes  ☐ No

Q.20 Overall, how would you rate the care you received from the hospital?

Excellent ☐  Very good ☐  Good ☐  Fair ☐  Poor ☐
Please answer the next set of questions even if your symptoms have gone away. If you do not have symptoms of heavy menstrual bleeding any more, please tick “not at all”.

Listed below are symptoms experienced by women who have heavy menstrual bleeding (heavy periods). Please consider each symptom as it relates to your heavy menstrual bleeding or menstrual cycle. Each question asks how much distress you have experienced from each symptom during the previous 3 months.

There are no right or wrong answers. Please be sure to answer every question by ticking (✓) the most appropriate box. If a question does not apply to you, please mark “not at all” as a response.

<table>
<thead>
<tr>
<th>During the previous 3 months, how distressed were you by…</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Some-what</th>
<th>A great deal</th>
<th>A very great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.21 Heavy bleeding during your menstrual period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.22 Passing blood clots during your menstrual period</td>
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</tr>
<tr>
<td>Q.23 Fluctuation in the duration of your menstrual period compared to your previous cycles</td>
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</tr>
<tr>
<td>Q.24 Fluctuation in the length of your monthly cycle compared to your previous cycles</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Q.25 Feeling tightness or pressure in your pelvic area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.26 Frequent urination during the daytime hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.27 Frequent nighttime urination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.28 Feeling fatigued</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Please answer the next set of questions even if your symptoms have gone away. If you do not have symptoms of heavy menstrual bleeding any more, please tick “none of the time”.

The following questions ask about your feelings and experiences regarding the impact of heavy menstrual bleeding symptoms (heavy periods) on your life. Please consider each question as it relates to your experiences with heavy menstrual bleeding during the previous 3 months.

There are no right or wrong answers. Please be sure to answer every question by ticking (✓) the most appropriate box. If the question does not apply to you, please tick “none of the time” as your option.

<table>
<thead>
<tr>
<th>During the previous 3 months, how often have your symptoms related to heavy menstrual bleeding...</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.29 Made you feel anxious about the unpredictable onset or duration of your periods?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.30 Made you anxious about travelling?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.31 Interfered with your physical activities?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.32 Caused you to feel tired or worn out?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.33 Made you decrease the amount of time you spent on exercise or other physical activities?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.34 Made you feel as if you are not in control of your life?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.35 Made you concerned about staining underclothes?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.36 Made you feel less productive?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.37 Caused you to feel drowsy or sleepy during the day?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.38 Made you feel self-conscious of weight gain?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.39 Made you feel that it was difficult to carry out your usual activities?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.40 Interfered with your social activities?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.41 Made you feel conscious about the size and appearance of your stomach?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q.42 Made you concerned about staining bed linen?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.43 Made you feel sad, discouraged, or hopeless?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.44 Made you feel down hearted and low?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.45 Made you feel exhausted?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.46 Caused you to be concerned or worried about your health?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.47 Caused you to plan activities more carefully?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.48 Made you feel inconvenienced about always carrying extra pads, tampons, and clothing to avoid accidents?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.49 Caused you embarrassment?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.50 Made you feel uncertain about your future?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.51 Made you feel irritable?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.52 Made you concerned about staining outer clothes?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.53 Affected the size of clothing you wear during your periods?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.54 Made you feel that you are not in control of your health?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.55 Made you feel weak as if energy was drained from your body?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.56 Diminished your sexual desire?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>Q.57 Caused you to avoid sexual relations?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
</tbody>
</table>
The following questions are about your health overall. By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

**Q.58 Mobility**
- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

**Q.59 Self-Care**
- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

**Q.60 Usual Activities** *(for example work, study, housework, family or leisure activities)*
- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

**Q.61 Pain/ Discomfort**
- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

**Q.62 Anxiety/ Depression**
- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed
Q.63 To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the black box below to whichever point on the scale indicates how good or bad your health state is today.

Please also write the number that represents your health today in the white boxes provided.

My health today (write number between 0 and 100 here)

Your own health state today

Thank you for completing this questionnaire.