Baseline Medical and Menstrual History

01	Date of assessment:	__ __ / __ __ / __ __ __ __ (dd/mm/yyyy)
02	Do you have any major medical problems? *Capture medical conditions and diagnoses on the Pre-existing Conditions Log*	☐ Yes ☐ No
03	Do you have any allergies: *Capture all allergies (including but not limited to drug, food, seasonal, environmental) on the Pre-existing Conditions Log.*	☐ Yes ☐ No
04	Do you currently take any medications, including oral, vaginal, herbal, other-the-counter or prescription medications? *Capture all current medications on the Concomitant Medications Log.*	☐ Yes ☐ No
05	Notes related to medical problems, allergies, concomitant meds:	
06	Do you know the date of your last menstrual period?	☐ Yes *(answer 06a)* ☐ No ☐ N/A - Amenorrhea

06a. Complete only if know first date of last menstrual period:

First day of last menstrual period: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)

07	What acceptable contraception method(s) are you using to prevent pregnancy? *Choose all that apply; document hormonal methods on Concomitant Medications Log.*	☐ Oral contraceptives → *Document hormonal methods on Con Med Log.* ☐ Injectable contraceptives (Depo) → *Document hormonal methods on Con Med Log.* ☐ Implant → *Document hormonal methods on Con Med Log.* ☐ IUD (non-copper) → *Document hormonal methods on Con Med Log.* ☐ Copper IUD → Date of copper IUD insertion: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy) ☐ Sterilization of participant → Date of sterilization: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy) ☐ Condoms (for US sites only) → Date you began using condoms: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy) ☐ Abstinence from penile-vaginal intercourse → Date began using abstinence: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy) ☐ Other, specify: ______________________________ ↓ Date you began using other contraception: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)

Baseline Medical and Menstrual History (continued)

08	Are you currently experiencing any vaginal symptoms or concerns?	☐ Yes *(answer 08a)* ☐ No

08a. Complete only if experiencing any vaginal symptoms or concerns:

Mark all vaginal symptoms that apply:	☐ Itching or irritation ☐ Abnormal discharge (different than fluctuations in discharge with participant's menstrual cycle or contraception) ☐ Abnormal odor (outside of normal) ☐ Discomfort or Pain ☐ Unexpected vaginal bleeding ☐ Other *(answer 08b)*

08b. Complete only if experiencing other vaginal symptoms or concerns:

Other vaginal symptom(s), specify: ____

09	Are you currently experiencing any urinary symptoms or concerns?	☐ Yes *(answer 09a)* ☐ No

09a. Complete only if experiencing any urinary symptoms or concerns:

Mark all urinary symptoms that apply:	☐ Burning with urination ☐ Frequency (urinating more than normal and not explained for instance by increased water intake) ☐ Urgency (feeling the urge or need to urinate but not being able to go) ☐ Other *(answer 09b)*

09b. Complete only if experiencing other urinary symptoms or concerns:

Other urinary symptom(s), specify: ____

CRF Completed By: ______ (initials)

CRF Completion Date: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)