

Baseline Medical and Menstrual History [V1]

01	Date of assessment:	___ / ___ / _____ (dd/mm/yyyy)
02	Do you have any medical problems? <small>! Capture medical conditions and diagnoses on the Pre-existing Conditions Log</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
03	Do you have any allergies: <small>! Capture all allergies (including but not limited to drug, food, seasonal, environmental) on the Pre-existing Conditions Log.</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
04	Do you currently take any medications, including oral, vaginal, herbal, over-the-counter or prescription medications? <small>! Capture all current medications on the Con Med Log.</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
05	Notes related to medical problems, allergies, and concomitant meds: <div style="border: 1px solid black; border-radius: 15px; height: 150px; margin-top: 10px;"></div>	
06	Do you know the date of your last menstrual period? <small>! An estimated day is acceptable if month & year are known</small>	<input type="checkbox"/> Yes (answer 06a, for exact or estimated date) <input type="checkbox"/> No <input type="checkbox"/> N/A – Amenorrhea (no menses for 3 months or more)

! 06a. Complete only one of the options below, if you know exact or estimated date of LMP:

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

Estimated day of last menstrual period: _____ (dd/mm/yyyy)

07	What acceptable contraception method(s) are you using to prevent pregnancy? <small>! Choose all that apply; document hormonal methods on Concomitant Medications Log.</small> <small>! Estimated dates are acceptable, refer to CCG document</small>	<input type="checkbox"/> Oral contraceptives → Document hormonal methods on Con Med Log. <input type="checkbox"/> Injectable contraceptives (Depo) → Document hormonal methods on Con Med Log. <input type="checkbox"/> Implant → Document hormonal methods on Con Med Log. <input type="checkbox"/> IUD (non-copper) → Document hormonal methods on Con Med Log. <input type="checkbox"/> Copper IUD → Date of copper IUD insertion: ___ / ___ / _____ (dd/mm/yyyy) <input type="checkbox"/> Sterilization of participant → Date of sterilization: ___ / ___ / _____ (dd/mm/yyyy) <input type="checkbox"/> Condoms (for US sites only) → Date you began using condoms: ___ / ___ / _____ (dd/mm/yyyy) <input type="checkbox"/> Other, specify: _____ ↓ Date you began using other contraception: ___ / ___ / _____ (dd/mm/yyyy)
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Baseline Medical and Menstrual History (continued)

08	Are you currently experiencing any vaginal symptoms or concerns?	<input type="checkbox"/> Yes (<i>answer 08a</i>) <input type="checkbox"/> No
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① *08a. Complete only if experiencing any vaginal symptoms or concerns:*

Mark all vaginal symptoms that apply:

	<input type="checkbox"/> Itching or irritation <input type="checkbox"/> Abnormal discharge (different than normal fluctuations in discharge) <input type="checkbox"/> Abnormal odor (outside of normal) <input type="checkbox"/> Discomfort or pain <input type="checkbox"/> Unexpected vaginal bleeding (or breakthrough bleeding) <input type="checkbox"/> Other (<i>answer 08b</i>)
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① *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?	<input type="checkbox"/> Yes (<i>answer 09a</i>) <input type="checkbox"/> No
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① *09a. Complete only if experiencing any urinary symptoms or concerns:*

Mark all urinary symptoms that apply:

	<input type="checkbox"/> Burning with urination <input type="checkbox"/> Increased frequency of urination <input type="checkbox"/> Urgency (feeling the urge or need to urinate but not being able to go) <input type="checkbox"/> Other (<i>answer 09b</i>)
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① *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)