Menstrual changes post COVID 19 vaccine – Subsequent questionnaire

You have kindly agreed to participate in this voluntary research study and have completed the initial survey at the time of your first vaccination. This is a follow up survey. The purpose of this study is to compare healthy women's menstrual pattern in the 3 months prior to the vaccine to 3, 6, 9 and 12 months post COVID 19 vaccine. Participating in this study will involve completing a secure online survey which takes about 10-15 minutes. Risks related to this research include the potential to feel uncomfortable answering questions about your body and health. Benefits related to this research include being able to share your experiences and contribute to an often-overlooked area of health research.

Responsible Principal Investigator: Dr Michal Amir, The Royal Women's Hospital, VIC Michal.Amir@thewomens.org.au

The survey will ask about your menstrual cycles, and your menstrual period, so please make sure you have that information available while you take the survey.

Statement of Confidentiality: In general, we will not tell anyone any information about you. When this research is discussed or published, no one will know that you were in the study. However, laws and university rules might require us to disclose information about you. For example, if required by laws or University Policy, study information which identifies you and the consent form signed by you may be seen or copied by the following people or groups:

- The Royal Women's Hospital Gynaecology research group.
- The University of Melbourne, Department of Obstetrics & Gynaecology

Whom to contact: If you have any questions or concerns during or after your participation, please contact Dr Michal Amir Michal.Amir@thewomens.org.au

*If you would like to consider participating in another study that includes endometrial lining sampling after COVID vaccine, please contact Dr Michal Amir Michal.Amir@thewomens.org.au

Personal Information

Please confirm if the following details are still correct

First name: _____

Surname:

Date of Birth: _____

Phone number:_____

Email:_____ (both are mandatory)

Select Correct/Incorrect

If incorrect

Please enter the new details _____

Date of questionnaire:_____

Have you fallen pregnant since your last survey? y/n
If yes

Are you still pregnant? y/n
If yes

How many weeks, or what is your due date?
If no

What was the outcome of the pregnancy? Miscarriage, termination of pregnancy, prefer not to answer

If miscarriage – how many weeks pregnant were you when you suffered a miscarriage?

Thank you for your participation in your study and for informing us of your pregnancy. As this study aims to assess how the Covid-19 vaccination impacts on menstrual periods we will not send you further surveys to complete.

Have you been diagnosed with COVID 19 infection in the lpast 3 months? Yes/no

Have you been diagnosed with any of the below conditions **since your last survey**? Yes/No

1. Uterine fibroids
2. Ovarian cysts
3. Polycystic ovaries
4. Endometriosis
5. Recurrent pelvic infections

1. Bleeding disorders
2. Hypothyroidism/Hyperthyroidism
3. Prolactinoma

If yes, please specify: _____

Regular medications: _____

Menstruation

In the last 3 months:

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)?

_____

were 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 the heaviest days since you last completed a survey:

Spotting ___ Light_____ Moderate_____ Heavy_____

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

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

If yes, how many times did this happen in the past 3 months?____ How many days did this bleeding last?

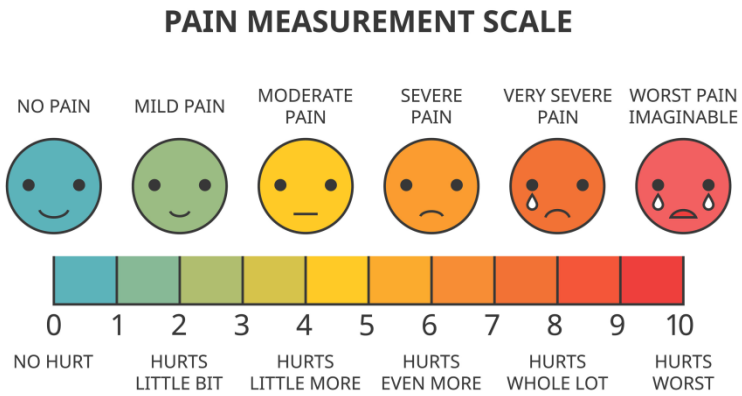
Was the bleeding pattern in the last 3 months typical of your periods normally? Y/N

If No, please expand _____

Pain:

Did you suffer from any pain during your periods? Yes / No

If yes, what was the intensity of the pain:



If you did experience significant period pain, did you lose days of work/studying or were restricted in other activities due to the pain? yes / no

Any other comments regarding your periods since you were vaccinated with the COVID vaccine?_____

Hormonal treatment

If you were taking/using any hormonal treatment to prevent pregnancy or for any other reason prior the first COVID vaccine, have you stopped or changed the treatment? Yes / No

If yes, when did you stop the treatment?_____

Have you started a new treatment? No/Yes-the pill/Implanon/Mirena/Kyeena/Copper IUD?

If so when?_____

Please comment on the changes to your hormone treatment/s_____

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

If first vaccination not given on day of initial survey

First vaccination date: _____

Second vaccination date: _____

What type of vaccine have you received: Pfizer Astra Zenca, Moderna, Novavax

If first vaccination was given on day of initial survey

Have you received a second dose of vaccination since your initial survey on *date of initial survey piped here* y/n

If yes Second vaccination date: _____

if no, ask again at 6 month survey

At all subsequent surveys ask

Have you received a booster vaccination (3rd dose or later) since your last survey

Date of booster dose:_____

Type of vaccine for booster dose: Pfizer, Astra Zeneca, Moderna, Novavax