

Appendix 1. Clinic Intake Form

This form is to be completed by clinic assistant

Date of Consent

Date of Birth

Medical Record Number

Enrollment Site

- South Main Clinic
- Community Health Center
- Planned Parenthood
- Other

Planned parenthood clinic

- Metro Clinic
- Salt Lake Clinic
- West Valley City Clinic
- South Jordan Clinic

Type of highly effective contraception method chosen today

- The copper IUD (Paragard)
- LNG IUD (Mirena)
- LNG IUD (Skyla)
- Contraceptive Implant (Nexplanon)
- Other

Please describe

Language

- English
- Spanish

First Name

Last Name

Street, City, State, ZIP

Phone number

(Include Area Code)

Is this a cell phone?

- Yes
- No

Is it ok to text this number?

- Yes
- No

Is it ok to leave a message?

- Yes
- No

was the phone number confirmed to be a working number in clinic today?

- Yes
- No

E-mail

Best way to contact participant

- Phone call
- Text
- Email
-

Other

Other, please specify:

Alternate Contact Information

Contact #1 name _____

Contact #1 phone number _____

Is it ok to leave a message? Yes
 No

Is it ok to text this number? Yes
 No

Contact #1 email address _____

Contact #2 name _____

Contact #2 phone number _____

Is it ok to leave a message? Yes
 No

Is it ok to text this number? Yes
 No

Contact #2 email address _____

Now we want to ask you a few questions about your menstrual period. If you use a period tracker you may want to use that to answer the following questions.

First, do you use a period tracker to track your periods? Yes
 No

Date of last menstrual period _____

How long was your previous cycle? (Cycles are from the start of one period to the start of your next period?) Typically 26-35 days _____

On average, how many days does your period last? (That is, how many days of bleeding do you have each cycle)? I don't get a period
 1-2
 3-4
 5-7
 8 or more
 It varies a lot
 I prefer not to answer

In the next section, we ask questions about unprotected sex or contraceptive failures you may have had recently. Remember that your answers are completely confidential, and your honest answers really help us with our research.

Have you had sex in the last 2 weeks where you did not use a method to prevent pregnancy or used a method where you were worried did not work (ie. condom broke, missed pill)

- No
- Yes
- I don't know
- I prefer not to answer

Please use a calendar to answer these questions:

Check here if you had sex on that day with no method of birth control

Check here if you had sex on that day and used a method where you were worried you might get pregnant. (for example: broken condom, missed birth control pills, etc.)

1 Day ago	<input type="checkbox"/>	<input type="checkbox"/>
2 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
3 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
4 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
5 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
6 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
7 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
8 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
9 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
10 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
11 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
12 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
13 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
14 Days ago	<input type="checkbox"/>	<input type="checkbox"/>
More than 14 days ago	<input type="checkbox"/>	<input type="checkbox"/>

When was your most recent episode of sex when you either did not use a method or were worried about method failure?

- Within 12 hours
- Within 24 hours
- Within 48 hours
- Within 72 hours
- Within 120 hours
- Beyond 5 days

To be completed after clinic visit....

Result of urine pregnancy test done in clinic today

- Not done
- Negative
- Positive

Result of urine LH test done in clinic today

- Not done
- Negative
- Positive

Urine sample collected?

- Yes
- No

Was device insertion successful?

- Failed insertion
- Successful insertion

Enrollment Survey

Welcome! Although 99% of women use birth control at some point in their lives, we still have lots to learn. This study will help us learn more about where people get information on birth control, as well as more about the relationship between birth control and people's sexual experiences. Findings could help improve the quality of reproductive health care.

We estimate that this survey will take you about 15 minutes to complete. Once you complete the survey, you will receive a \$20 gift card as a thank you for your time.

Do your best to answer each question, and remember that all information is completely confidential.

Thank you warmly for your participation.

Participant Background First, please tell us a little bit about yourself.

Were you born in the United States?

- Yes
- No
- I prefer not to answer

In what country were you born?

What year did you move to the United States?

Which of the following best describes your ethnicity/race?

- White
- Hispanic or Latina
- Asian
- Native Hawaiian or Pacific Islander
- American Indian or Alaska Native
- African American or Black
- Other
- I don't know
- I prefer not to answer

If other please describe.

What is your marital status?

- Never married
- Not married but living with a partner
- Married
- Separated
- Divorced
- Widowed
- I prefer not to answer

Which of the following best describes your sexual identity?

- Heterosexual (Straight)
- Homosexual (Gay/Lesbian)
- Bisexual
- Other
- I don't know
- I prefer not to answer

What type of medical insurance do you currently have?

- None
 - Medicaid
 - Disability or Medicare
 - Insurance through your job or that you buy on your own
 - Military or VA (Champus, ChampVA, Tricare)
 - Student health insurance
 - Parent's insurance
 - I don't know
 - I prefer not to answer
- (check all that apply)

The next few questions are about your current employment.

What best describes your current employment status?

- Unemployed
- Working full-time (at least 30 hrs/wk)
- Working part-time (less than 30 hrs/wk)
- Disabled or on sick leave
- Retired
- Homemaker
- Student
- Other
- I prefer not to answer

If other employment, please describe.

How many hours do you work each week?

(Please guess if you are not sure)

What is your hourly wage?

(Please estimate if you are not sure)

What kind of work do you do?

Are you currently looking for work, additional work, or different work?

- No
- Yes
- Don't Know
- I prefer not to answer this question

The next few questions are about your education level and education level of your parents.

Are you currently in school, either full-time or part-time?

- Not at all
- Part time
- Full time
- I prefer not to answer this question

What type of degree are you seeking?

- High school diploma
- Technical school
- Community College
- Certificate
- College or University
- Graduate School
- I prefer not to answer this questions

Please specify type

What date do you expect to graduate?

What best describes the highest level of education you have COMPLETED SO FAR?

- 11th grade or less
- 12th grade (completed high school or GED)
- Vocational/technical training
- Associate degree or some college
- 4-year college degree (BA/BS)
- Any graduate or professional education (any time in a Masters, JD, PhD, MD, etc. program)
- I don't know
- I prefer not to answer

What best describes your PLANS for the highest level of education in the future?

- None, I am done with school and do not have plans to go back
- I plan to finish high school or GED
- Get vocational/technical training
- Get an associate degree
- Get a 4-year college degree (BA/BS)
- Get graduate or professional education (Masters, JD PhD, MD)
- I don't know
- I prefer not to answer

What is the highest level of education your mother (or female guardian) completed?

- Less than High School
- High School degree or GED
- Vocational/technical training
- Associate degree or some college
- 4-year college degree (BA/BS)
- Any graduate or professional education (any time in a Masters, JD, PhD, MD, etc.)
- I don't know
- I prefer not to answer

What is the highest level of education your father (or male guardian) completed?

- Less than High School
- High School degree or GED
- Vocational/technical training
-
-
-

-
-
- Associate degree or some college
 - 4-year college degree (BA/BS)
 - Any graduate or professional education (any time in a Masters, JD, PhD, MD, etc.)
 - I don't know
 - I prefer not to answer

Just a few more questions about your financial situation.

Please check all of the following have been a source of income in the last month:

- Self
- Spouse or Partner
- Other family member
- Government assistance
- Other
- I prefer not to answer

What other sources of income did you receive in the past month?

How much money did you make last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

How much money did your partner or spouse make last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

How much money did your other family contribute to your household income?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

How much money did government assistance contribute to your household income last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
-
-
-
-
-
-

\$1,601-\$2,000
\$2,001-\$2,400
\$2,401-\$2,800
More than \$2,800
Don't know
I prefer not to answer

How much money did you receive from other sources last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

What is your annual household income?

- Less than \$10,000
- \$10,000-\$19,999
- \$20,000-\$29,999
- \$30,000-\$39,999
- \$40,000-\$49,999
- \$50,000-\$59,999
- \$60,000-\$69,999
- \$70,000-\$79,999
- \$80,000 or more
- I don't know
- I prefer not to answer this question

How many dependents does this income support?

How many children under the age of 5 do you have living with you?

Were you supposed to receive any child support in the last 4 weeks?

- No
- Yes
- I prefer not to answer

How much child support were you supposed to receive?

Did you receive any child support last month?

- No
- Yes
- I prefer not to answer this question

How much child support did you receive last month?

Which of the following best describes your current housing situation?

- Homeless
- Shelter
- Mobile home
- Apartment
- Single-family house
- Other
- I prefer not to answer this question

Describe type of housing

We will now ask a few questions about public assistance that you may receive: Do you currently receive:

	No	Yes	Prefer not to answer
Food stamps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WIC (Women, Infants and Children)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Welfare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unemployment Benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Just a few more questions about your economic situation. During the past 12 months, have you had trouble paying for the following:

	No	Yes	Prefer not to answer
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical care or medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past month, how often would you say you had enough money to meet your basic living needs such as food, housing and transportation?

- All the time
- Most of the time
- Some of the time
- Rarely
- Never
- Don't Know
- Refused

Thanks for your answers so far. Now we want to ask you about your visit to the clinic today.

What is the main reason you came to the clinic today?

- Annual check-up and/or well woman exam, including pap smear
- To get birth control
- To get emergency contraception
- Pregnancy testing
- STI/STD testing
- Abortion services
- To get free or low cost birth control and participate in this study
- I prefer not to answer
- Other

If "other," please describe your reason for coming to the clinic today.

How did you hear about the services that this clinic provides?

- Family, friend, or partner
 - School class or school teacher
 - Health care provider or other clinic
 - Facebook/Twitter or other social media
 - Bedsider.org
 - Other website
 - Television, radio, or newspaper
 - Other
 - I have been to the clinic before
 - I don't know
 - I prefer not answer
- (select all that apply)

If other, please specify:

Have you ever visited the website www.bedsider.org?

- Yes
- No
- I don't know
- I prefer not to answer

If you have visited the website www.bedsider.org, how did you learn about it?

- Family, friend, or partner
 - School class or school teacher
 - Health care provider or other clinic
 - Facebook/Twitter or other social media
 - Other website
 - Billboards or flyers
 - Television, radio, or newspaper
 - Other
 - I don't know
 - I prefer not answer
- (select all that apply)

If other, please specify:

Now we want to ask you some questions about your pregnancy history.

Have you ever been pregnant before?

- No
- Yes
- Prefer not to answer

How old were you when you became pregnant for the FIRST time

When did your MOST RECENT pregnancy end? If you can't remember the exact date, please make your best guess.

How did your most recent pregnancy end?

- Miscarriage
- Abortion
- Live birth
- Prefer not to answer

Have you ever been pregnant when you did not want to be pregnant?

- Yes
- No
- I prefer not to answer

Now we want to ask you some questions about methods you have used to prevent pregnancy.

What method(s) to prevent pregnancy have you EVER used in the past?

- None; I never used any method to prevent pregnancy
- Withdrawal
- Male condom
- Female condom
- Fertility Awareness Method / Natural Family Planning / Rhythm Method
- Cervical cap or sponge
- Spermicide
- Diaphragm
- Oral contraceptive, "The Pill"
- Contraceptive patch (Ortho Evra)
- Vaginal ring (NuvaRing)
- 3 month injection (Depo-Provera)
- 3 year hormonal IUD (Skyla)
- 5 year hormonal IUD (Mirena)
- Non-hormonal copper IUD (Paragard)
- Sterilization (tied tubes, hysterectomy or male partner has had a vasectomy)
- Emergency contraception (Plan B, Ella, Next Choice, or The Morning After Pill)
- Other
(select all that apply)

What method(s) to have you used in the last 4 weeks? This should not include the method you are receiving today.

- None; I am not using any contraceptive method
- Withdrawal
- Male condom
- Female condom
- Fertility Awareness Method / Natural Family Planning / Rhythm Method
- Cervical cap or sponge
- Spermicide
- Diaphragm
- Oral contraceptive, "The Pill"
- Contraceptive patch (Ortho Evra)
- Vaginal ring (NuvaRing)
- 3 month injection (Depo-Provera)
- 3 year hormonal IUD (Skyla)
- 5 year hormonal IUD (Mirena)
- Non-hormonal copper IUD (Paragard)
- Sterilization (tied tubes, hysterectomy or male partner has had a vasectomy)
- Emergency contraception (Plan B, Ella, Next Choice, or The Morning After Pill)
- Other
(select all that apply)

If other, please specify:

How long have you been on this method of birth control? If you are using multiple methods answer any hormonal method.

- less than 3 months
- 3 to 6 months
- 6 months to 1 year
-
-
-
-
-

-
-
- 1 to 2 years
 - 2 to 3 years
 - more than 3 years
 - I don't know
 - I prefer not to answer
-

How many years have you used this method of birth control?

Overall, how satisfied are you with the method you are using?

- Completely satisfied
- Somewhat satisfied
- Neither satisfied or dissatisfied
- Somewhat dissatisfied
- Completely dissatisfied
- I prefer not to answer

Overall, how confident are you that your birth control will prevent pregnancy?

- Very high confidence
- High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence
- I prefer not to answer

Please rate your agreement or disagreement with the following statement: "I feel that I have control over whether or not I get pregnant."

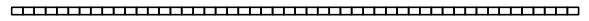
- I strongly agree
- I somewhat agree
- I neither agree nor disagree
- I somewhat disagree
- I strongly disagree
- I prefer not to answer

The next few questions ask about how birth control has affected your sex life.

On a scale of 1 to 100, how might you rank your sex life right now?

worst possible

best possible



(Place a mark on the scale above)

In the last 4 weeks, would you say that your birth control or method to avoid pregnancy has:

- Made your sex life better
- Made your sex life worse
- Had no effect on my sex life

Briefly explain the impact your current method to avoid pregnancy has on your sex life.

How important are each of the following characteristics to you in deciding which birth control method to use?

	Not at all important	Slightly important	Quite important	Extremely important	I don't know/ I prefer not to answer
It doesn't contain hormones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is acceptable to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It doesn't interrupt sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It doesn't reduce my libido	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is in line with my religious beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is recommended by my friend(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is the most effective method	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Now we want to ask you a few questions about certain aspects of your health and well-being that may be related to your menstrual cycle. In the past 4 weeks, have any the following health issues been a problem for you?

	Have not had in the past 30 days	Once a month	A couple of days a month	Once a week	A couple of days a week	Everyday	Don't know or prefer not to answer
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moodiness or irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne flare-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cramping Weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gain Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you sought medical care for any of these conditions?

- Yes
- No
- Don't know

If so, please specify which one(s):

Were you prescribed medication to treat these conditions?

- Yes
- No

Next, we want to gather information about your sexual relationships. Please remember that everything you say is confidential. For these questions, we are interested in your relationships with members of the opposite sex. We recognize some people are in same-sex relationships, but the focus of this study relates to sex between women and men.

Have you been sexually active with a male partner in the past four weeks? This may include a variety of activities, not just vaginal intercourse.

- No
- Yes
- I prefer not to answer

How long have you been in your sexual relationship?

- less than 3 months
- 3 to 6 months
- 6 months to 1 year
- 1 to 2 years
- 2 to 3 years
- more than 3 years

Note: If you have more than one partner, think about your primary/main partner when answering.

If you have been in a relationship with your primary sexual partner for more than 3 years, please tell us how many years it has been.

(years)

We will now ask you a few questions about your sexual feelings and responses during the past four weeks.

Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?

- Very high
- High
- Moderate
- Low
- Very low or none at all
- Prefer not to answer

Over the past 4 weeks, how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?

- No sexual activity
- Very high
- High
- Moderate
- Low
- Very low or none at all
- Prefer not to answer

Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

Over the past 4 weeks, how satisfied have you been with your overall sexual life?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied
- Prefer not to answer

Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

The following items relate to your sexual experiences. You might find a few of the items similar to items you just filled out. That's okay; just do your best to answer all the questions. When responding to these items, please think about the last 4 weeks. Thinking about the last month, how satisfied or dissatisfied are you with each of the following issues?

	not at all satisfied	a little satisfied	moderately satisfied	very satisfied	extremely satisfied	I prefer not to answer
The intensity of my sexual arousal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The quality of my orgasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My letting go and surrender to sexual pleasure during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My focus and concentration during sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way I sexually react to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My body's sexual functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My emotional opening up in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My mood after sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The frequency of my orgasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The pleasure I provide to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The balance between what I give and receive in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's emotional opening up during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's initiation of sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's ability to orgasm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's surrender to sexual pleasure (letting go)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way my partner takes care of my sexual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's sexual creativity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's sexual availability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The variety of my sexual activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The frequency of my sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any concern about your sexual functioning?

- No
- Yes
- I don't know

Please briefly describe.

The last few items have to do with more general health and well-being.

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt calm and relaxed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt active and vigorous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I woke up feeling fresh and rested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My daily life has been filled with things that interest me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Followup Survey (1, 3, & 6 months)

Welcome back! Thank you again for participating. We would like to follow-up with you about your experiences during since you enrolled in this study. Findings could help improve the quality of reproductive health care.

We estimate that this survey will take you less than 10 minutes to complete. Once you complete the survey, you will receive a credit toward a \$20 gift card which you will receive after the 6 month survey.

Do your best to answer each question, and remember that all information is completely confidential.

Thank you warmly for your participation.

Thank you very much for participating in this study. First we want to make sure you haven't changed any of your contact information.

Has any of your contact information changed (for example, your phone number, email, or address)?

- Yes
- No

If so, which contact info has changed? Please check all that apply.

- New phone number
 - New email
 - New address
- (check all that apply)

Please list your new phone number.

(xxx-xxx-xxxx)

Please list your new email address.

Please list your new mailing address.

We will start by asking you a few questions about the contraception that you selected at the beginning of the study.

Are you still using the IUD or Implant that you received at the beginning of this study?

- No
- Yes
- I don't know

In the last 4 weeks, have you checked to make sure your IUD is still in place?

- No, I have not
- Yes, I felt my strings myself and confirmed its still there
- Yes, I had a provider check my string
- I tried but was not able to feel my strings

How long do you plan on using the IUD or Implant that you have?

- Less than 1 year
- More than 1 year but less than 2 years
- More than 2 years but less than 3 years
- More than 3 years but less than 5 years
- More than 5 years but less than 10 years
- More than 10 years
- Unsure
- I prefer not to answer this question

What are the reasons you are no longer using your IUD or Implant?

- It fell out
- Excessive bleeding
- Cramping
- Pain
- Breast symptoms
- Weight gain
- Moodiness or depression
- Bloating
- Skin problems
- Pain during intercourse
- Partner could feel it
- I wanted to get pregnant
- I had a positive pregnancy test
- Other

If other, please specify:

When was the date the device removed or fell out?

Which of the following best describes your vaginal bleeding in the past 4 weeks?

- I've had no vaginal bleeding
- I've had less bleeding than before the device
- I've had no change from before the device
- I've had more bleeding than before the device

The next questions are about any pregnancy or health issues that may be related to your contraception since you entered the study.

In the last four weeks, have you taken a pregnancy test?

- No
- Yes, I took a test at home
- Yes, I took a test in a clinic
- I don't know

What were the results of your pregnancy test?

- Negative
- Positive
- I don't know

What was the date of your positive pregnancy test?

If you have had a positive pregnancy test, please indicate the outcome of the pregnancy.

- I had or am planning to have an abortion
- I had a miscarriage
- I had an ectopic pregnancy
- I am planning on continuing the pregnancy and keeping the baby
- I am planning on continuing the pregnancy and giving the baby up for adoption
- I am unsure of what I am going to do
- I have not had a positive pregnancy test

What was the date when your pregnancy ended, regardless of the outcome?

To ensure your safety, if you had a pregnancy, we will follow-up on the care you received. Please provide the name of the clinic or hospital where you were seen?

Since enrolling in the study, have you been hospitalized for any illness or injury?

- Yes
- No

Please provide the date:

Please explain what happened:

Have you seen a medical provider for an issue that you thought might be related to the IUD or contraceptive implant you had inserted?

- Yes
- No

Please provide the date:

Please describe:

Now we want to ask you some questions about birth control. Think about the method(s) you have been using in the last 4 weeks.

What method(s) to prevent pregnancy have you used in the last 4 weeks?

- None; I am not using any contraceptive method
- Withdrawal
- Male condom
- Female condom
- Fertility Awareness Method / Natural Family Planning / Rhythm Method
- Cervical cap or sponge
- Spermicide
- Diaphragm
- Oral contraceptive, "The Pill"
- Contraceptive patch (Ortho Evra)
- Vaginal ring (NuvaRing)
- 3 month injection (Depo-Provera)
- 3 year hormonal IUD (Skyla)
- 5 year hormonal IUD (Mirena)
- Non-hormonal copper IUD (Paragard)
- Contraceptive Implant (Nexplanon)
- Sterilization (tied tubes, hysterectomy or male partner has had a vasectomy)
- Emergency contraception (Plan B, Ella, Next Choice, or The Morning After Pill)
- Other
(select all that apply)

If other, please specify:

Overall, how satisfied are you with your birth control?

- Completely satisfied
- Somewhat satisfied
- Neither satisfied or dissatisfied
- Somewhat dissatisfied
- Completely dissatisfied
- I prefer not to answer

Overall, how confident are you with your birth control?

- Very high confidence
- High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence
- I prefer not to answer

Please rate your agreement or disagreement with the following statement: "I feel that I have control over whether or not I get pregnant."

- I strongly agree
- I somewhat agree
- I neither agree nor disagree
- I somewhat disagree
- I strongly disagree
- I prefer not to answer

Now we want to ask you a few questions about certain aspects of your health and well-being that may be related to your menstrual cycle. In the past 4 weeks, have any the following health issues been a problem for you?

	Have not had in the past 30 days	Once a month	A couple of days a month	Once a week	A couple of days a week	Everyday	Don't know
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moodiness or irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne flare-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cramping Weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gain Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you sought medical care for any of these conditions?

- Yes
- No
- Don't know

If so, please specify which one(s):

Were you prescribed medication to treat these conditions?

- Yes
- No

Next, we want to gather information about your sexual relationships. Please remember that everything you say is confidential. For these questions, we are interested in your relationships with members of the opposite sex. We recognize some people are in same-sex relationships, but the focus of this study relates to sex between women and men.

Have you been sexually active in the past four weeks?

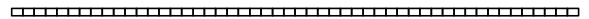
- No
- Yes
- I prefer not to answer

Is this partner the same person you were having sex with when you took the previous survey 4 weeks ago?

- No
- Yes
- I prefer not to answer

On a scale of 1 to 100, how might you rank your sex life right now?

worst possible best possible



(Place a mark on the scale above)

What do you think would have to change to bring it to a 100?

In the last 4 weeks, would you say that your contraceptive method has...

- Made your sex life better
- Made your sex life worse
- Had no effect on my sex life

Please explain the impact your current contraceptive method has on your sex life.

Do you have any concern about your sexual functioning?

- No
- Yes
- I don't know

Please briefly describe.

We will now ask you a few questions about your sexual feelings and responses during the past four weeks. Just do your best to answer each one.

Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?

- Very high
- High
- Moderate
- Low
- Very low or none at all
- Prefer not to answer

Over the past 4 weeks, how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?

- No sexual activity
- Very high
- High
- Moderate
- Low
- Very low or none at all
- Prefer not to answer

Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

Over the past 4 weeks, how satisfied have you been with your overall sexual life?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied
- Prefer not to answer

Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

The following items relate to your sexual experiences. You might find a few of the items similar to items you just filled out. That's okay; just do your best to answer all the questions. When responding to these items, please think about the last 4 weeks. Thinking about the last month, how satisfied or dissatisfied are you with each of the following issues?

	not at all satisfied	a little satisfied	moderately satisfied	very satisfied	extremely satisfied	I prefer not to answer
The intensity of my sexual arousal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The quality of my orgasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My letting go and surrender to sexual pleasure during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My focus and concentration during sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way I sexually react to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My body's sexual functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My emotional opening up in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My mood after sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The frequency of my orgasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The pleasure I provide to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The balance between what I give and receive in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's emotional opening up during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's initiation of sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's ability to orgasm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's surrender to sexual pleasure (letting go)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way my partner takes care of my sexual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's sexual creativity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's sexual availability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The variety of my sexual activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The frequency of my sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The last few items have to do with more general health and well-being. Please think about your experiences in the last four weeks when answering.

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt calm and relaxed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt active and vigorous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I woke up feeling fresh and rested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My daily life has been filled with things that interest me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you again for participating in this study. In the space below, feel free to tell us anything else you wish about your experience with your contraception or participation in this study. Otherwise, we will be in touch with you when it's time for the next part of the study.

Comments:

Brief Followup Survey (1, 2, & 3 years)

Welcome Back! As you'll remember, this study is helping us learn more about relationship between people's birth control experiences. As researchers, we have much more to learn about this topic, and so what we learn in this survey will be very helpful to us. Findings could help improve the quality of reproductive health care.

We estimate that this survey will take you about 10 minutes to complete. Once you complete the survey, you will receive a \$20 gift card credit as a thank you for your time.

Do your best to answer each question, and remember that all information is completely confidential.

Thank you warmly for your participation.

Thank you very much for participating in this study. First we want to make sure you haven't changed any of your contact information.

In the six months, has any of your contact information changed (that is, your phone number, email, or address)?

- Yes
 No

If so, which contact info has changed?

- New phone number
 New email
 New address
(check all that apply)

Please enter in your new phone number.

(xxx-xxx-xxxx)

Please enter in your new email address.

Please enter in your latest address.

We will start by asking you a few questions about your clinic visit last month.

Are you still using the IUD or Implant that you received at the beginning of this study?

- No
- Yes
- I don't know

In the last 4 weeks, have you checked to make sure your IUD is still in place?

- No, I have not
- Yes, I felt my strings myself and confirmed its still there
- Yes, I had a provider check my string
- I tried but was not able to feel my strings

How long do you plan on using the IUD or Implant that you have?

- I did not get an IUD or Implant
- Less than 1 year
- More than 1 year but less than 2 years
- More than 2 years but less than 3 years
- More than 3 years but less than 5 years
- More than 5 years but less than 10 years
- More than 10 years
- Unsure
- I prefer not to answer this question

What are the reasons you are no longer using your IUD or Implant?

- It fell out
- Excessive bleeding
- Cramping
- Pain
- Breast symptoms
- Weight gain
- Moodiness or depression
- Bloating
- Skin problems
- Pain during intercourse
- Partner could feel it
- I wanted to get pregnant
- I had a positive pregnancy test
- Other

If other, please specify:

What was the date the device fell out or was removed? If you can't remember the exact date, just make your best guess.

Now we want to ask you some questions about birth control. Please think about about all the method(s) you may have used, including the IUD or implant.

What method(s) to prevent pregnancy have you used in the last 4 weeks?

- None; I am not using any contraceptive method
- Withdrawal
- Male condom
- Female condom
- Fertility Awareness Method / Natural Family Planning / Rhythm Method
- Cervical cap or sponge
- Spermicide
- Diaphragm
- Oral contraceptive, "The Pill"
- Contraceptive patch (Ortho Evra)
- Vaginal ring (NuvaRing)
- 3 month injection (Depo-Provera)
- 3 year hormonal IUD (Skyla)
- 5 year hormonal IUD (Mirena)
- Non-hormonal copper IUD (Paragard)
- Sterilization (tied tubes, hysterectomy or male partner has had a vasectomy)
- Emergency contraception (Plan B, Ella, Next Choice, or The Morning After Pill)
- Other
(select all that apply)

If other, please specify: _____

Overall, how satisfied are you with your birth control?

- Completely satisfied
- Somewhat satisfied
- Neither satisfied or dissatisfied
- Somewhat dissatisfied
- Completely dissatisfied
- I prefer not to answer

Overall, how confident are you with your birth control?

- Very high confidence
- High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence
- I prefer not to answer

Please rate your agreement or disagreement with the following statement: "I feel that I have control over whether or not I get pregnant."

- I strongly agree
- I somewhat agree
- I neither agree nor disagree
- I somewhat disagree
- I strongly disagree
- I prefer not to answer

The next few questions are about your current employment.

What best describes your current employment status?

- Unemployed
- Working full-time (at least 30 hrs/wk)
- Working part-time (less than 30 hrs/wk)
- Disabled or on sick leave
- Retired
- Homemaker
- Student
- Other
- I prefer not to answer

If other employment, please describe.

How many hours do you work each week?

(Please guess if you are not sure)

What kind of work do you do?

Are you currently looking for work, additional work, or different work?

- No
- Yes
- Don't Know
- I prefer not to answer this question

The next few questions are about your education.

Are you currently in school, either full-time or part-time?

- Not at all
- Part time
- Full time
- I prefer not to answer this question

What type of degree are you seeking?

- High school diploma
- Technical school
- Community College
- Certificate
- College or University
- Graduate School
- I prefer not to answer this questions

Please specify type

What date do you expect to graduate?

What best describes the highest level of education you have COMPLETED SO FAR?

- 11th grade or less
- 12th grade (completed high school or GED)
- Vocational/technical training
- Associate degree or some college
- 4-year college degree (BA/BS)
- Any graduate or professional education (any time in a Masters, JD, PhD, MD, etc. program)
- I don't know
- I prefer not to answer

What best describes your PLANS for the highest level of education in the future?

- None, I am done with school and do not have plans to go back
- I plan to finish high school or GED
- Get vocational/technical training
- Get an associate degree
- Get a 4-year college degree (BA/BS)
- Get graduate or professional education (Masters, JD PhD, MD)
- I don't know
- I prefer not to answer

Just a few more questions about your financial situation.

Please check all of the following have been a source of income in the last month:

- Self
- Spouse or Partner
- Other family member
- Government assistance
- Other
- I prefer not to answer

What other sources of income did you receive in the past month?

How much money did you make last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

How much money did your partner or spouse make last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

How much money did your other family contribute to your household income?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

How much money did government assistance contribute to your household income last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
-
-
-
-
-
-

\$1,601-\$2,000
\$2,001-\$2,400
\$2,401-\$2,800
More than \$2,800
Don't know
I prefer not to answer

How much money did you receive from other sources last month?

- None
- \$1-\$400
- \$401-\$800
- \$801-\$1,200
- \$1,201-\$1,600
- \$1,601-\$2,000
- \$2,001-\$2,400
- \$2,401-\$2,800
- More than \$2,800
- Don't know
- I prefer not to answer

What is your annual household income?

- Less than \$10,000
- \$10,000-\$19,999
- \$20,000-\$29,999
- \$30,000-\$39,999
- \$40,000-\$49,999
- \$50,000-\$59,999
- \$60,000-\$69,999
- \$70,000-\$79,999
- \$80,000 or more
- I don't know
- I prefer not to answer this question

How many dependents does this income support?

How many children under the age of 5 do you have living with you?

Were you supposed to receive any child support in the last 4 weeks?

- No
- Yes
- I prefer not to answer

How much child support were you supposed to receive?

Did you receive any child support last month?

- No
- Yes
- I prefer not to answer this question

How much child support did you receive last month?

Which of the following best describes your current housing situation?

- Homeless
- Shelter
- Mobile home
- Apartment
- Single-family house
- Other
- I prefer not to answer this question

Describe type of housing

We will now ask a few questions about public assistance you may receive: Do you currently receive:

	No	Yes	Prefer not to answer
Food stamps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WIC (Women, Infants and Children)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Welfare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unemployment Benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Just a few more questions about your economic situation. During the past 12 months, have you had trouble paying for the following:

	No	Yes	Prefer not to answer
Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical care or medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past month, how often would you say you had enough money to meet your basic living needs such as food, housing and transportation?

- All the time
- Most of the time
- Some of the time
- Rarely
- Never
- Don't Know
- Refused

The last few items have to do with more general health and well-being. Please think about the last 4 weeks when responding to these items.

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt calm and relaxed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt active and vigorous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I woke up feeling fresh and rested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My daily life has been filled with things that interest me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The final questions are about any health issues that may be related to your contraception.

Have you had a positive pregnancy test since the last survey?

- No
- Yes
- I don't know

What was the date of your positive pregnancy test?

If you have had a positive pregnancy test please describe what was the outcome of the pregnancy?

- I had or am planning to have an abortion
- I had a miscarriage
- I had an ectopic pregnancy
- I am planning on continuing the pregnancy and keeping the baby
- I am planning on continuing the pregnancy and giving the baby up for adoption
- I am unsure of what I am going to do
- I have not had a positive pregnancy test

What was the date when your pregnancy ended, regardless of the outcome?

To ensure your safety, if you had a pregnancy, we will follow-up on the care you received. Please provide the name of the clinic or hospital where you were seen?

Since enrolling in the study, have you been hospitalized for any illness or injury?

- Yes
- No

Please provide the date:

Please explain what happened:

Have you seen a medical provider for an issue that you thought might be related to the IUD or contraceptive implant you had inserted?

- Yes
- No

Please provide the date:

Please describe:

Thank you again for participating in this study. Feel free to tell us anything about your experience with your contraception or participation in this study.

Comments:

Brief Followup Survey (18 & 30 months)

Welcome Back! As you'll remember, this study is helping us learn more about relationship between people's birth control experiences. As researchers, we have much more to learn about this topic, and so what we learn in this survey will be very helpful to us. Findings could help improve the quality of reproductive health care.

We estimate that this survey will take you about 5 minutes to complete.

Do your best to answer each question, and remember that all information is completely confidential.

Thank you warmly for your participation.

Thank you very much for participating in this study. First we want to make sure you haven't changed any of your contact information.

Has any of your contact information changed in the last six months (for example, your telephone number, email, or address)?

- Yes
 No

If so, which contact info has changed?

- New phone number
 New email
 New address
(check all that apply)

Please provide your new phone number.

(xxx-xxx-xxxx)

Please provide your new email address.

Please provide your new address.

We will start by asking you a few questions about your clinic visit a year and a half ago. This was the visit when you wanted an IUD or implant and when you enrolled in our study.

Are you still using the IUD or Implant that you received at the beginning of this study?

- No
 Yes
 I don't know

In the last 4 weeks, have you checked to make sure your IUD is still in place?

- No, I have not
- Yes, I felt my strings myself and confirmed its still there
- Yes, I had a provider check my string
- I tried but was not able to feel my strings

What are the reasons you are no longer using your IUD or Implant?

- It fell out
- Excessive bleeding
- Cramping
- Pain
- Breast symptoms
- Weight gain
- Moodiness or depression
- Bloating
- Skin problems
- Pain during intercourse
- Partner could feel it
- I wanted to get pregnant
- I had a positive pregnancy test
- Other

If other, please specify:

On what day did the device fell out or was removed?
If you can't remember the exact date, just make your best guess.

Now we want to ask you some questions about birth control. Please think about about all the method(s) you may have used recently, including the IUD or implant.

What method(s) to prevent pregnancy have you used in the last 4 weeks?

- None; I am not using any contraceptive methods
- Withdrawal
- Male condom
- Female condom
- Fertility Awareness Methods / Natural Family Planning / Rhythm Method
- Cervical cap or sponge
- Spermicide
- Diaphragm
- Oral contraceptive, "The Pill"
- Contraceptive patch (Ortho Evra)
- Vaginal ring (NuvaRing)
- 3 month injection (Depo-Provera)
- 3 year hormonal IUD (Skyla)
- 5 year hormonal IUD (Mirena)
- Non-hormonal copper IUD (Paragard)
- Sterilization (tied tubes, hysterectomy or male partner has had a vasectomy)
- Emergency contraception (Plan B, Ella, Next Choice, or The Morning After Pill)
- Other
(select all that apply)

If other, please specify:

Overall, how satisfied are you with your birth control?

- Completely satisfied
- Somewhat satisfied
- Neither satisfied or dissatisfied
-
-
-

Somewhat dissatisfied
Completely dissatisfied
I prefer not to answer

Overall, how confident are you with your birth control?

- Very high confidence
- High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence
- I prefer not to answer

Please rate your agreement or disagreement with the following statement: "I feel that I have control over whether or not I get pregnant."

- I strongly agree
- I somewhat agree
- I neither agree nor disagree
- I somewhat disagree
- I strongly disagree
- I prefer not to answer

The final questions are about any pregnancies or health issues that may be related to your contraception.

Have you had a positive pregnancy test since the last survey? (That is, in the last six months?)

- No
- Yes
- I don't know

What was the date of your positive pregnancy test?

If you have had a positive pregnancy test please describe what was the outcome of the pregnancy?

- I had or am planning to have an abortion
- I had a miscarriage
- I had an ectopic pregnancy
- I am planning on continuing the pregnancy and keeping the baby
- I am planning on continuing the pregnancy and giving the baby up for adoption
- I am unsure of what I am going to do
- I have not had a positive pregnancy test

To ensure your safety, if you had a pregnancy, we will follow-up on the care you received. Please provide the name of the clinic or hospital where you were seen?

Since enrolling in the study, have you been hospitalized for any illness or injury?

- Yes
- No

Please provide the date:

Please explain what happened:

Have you seen a medical provider for an issue that you thought might be related to the IUD or contraceptive implant you had inserted?

- Yes
- No

Please provide the date:

Please describe:

Thank you again for participating in this study. In the space below, feel free to tell us anything about your experience with your contraception or participation in this study. Otherwise, we will be in touch in the future.

Comments:

Final Study Status

Please complete the survey below.

Thank you!

Final Study Status

- Never had the device inserted/failed insertion
- No longer using a device
- Withdrew Consent/No longer wants to participate
- Study Complete
- Lost to follow-up
- Other

If other, please explain.

What are the reasons you are no longer using your IUD or Implant?

- It fell out
- Excessive bleeding
- Cramping
- Pain
- Breast symptoms
- Weight gain
- Moodiness or depression
- Bloating
- Skin problems
- Pain during intercourse
- Partner could feel it
- Problems with my libido/sex life
- I wanted to get pregnant
- I had a positive pregnancy test
- Other

If other, please specify:

When was the date the device removed or fell out?

Study Outcome

- Expulsion
- Removal
- Pregnancy w/ device
- Continuing device @ 6 months
- Lost to follow-up

Last Survey Completed

- Enrollment
- 4-week
- 3-month
- 6-month
- 12-month
- 18-month
- 24-month
- 30-month
- 36-month

Date of Final Contact

Contact notes

Clinical Notes

Followup Survey (1, 3, & 6 months)

Welcome back! Thank you again for participating. We would like to follow-up with you about your experiences during since you enrolled in this study. Findings could help improve the quality of reproductive health care.

We estimate that this survey will take you less than 10 minutes to complete. Once you complete the survey, you will receive a credit toward a \$20 gift card which you will receive after the 6 month survey.

Do your best to answer each question, and remember that all information is completely confidential.

Thank you warmly for your participation.

Has any of your contact information changed (for example, your phone number, email, or address)?

- Yes
 No

If so, which contact info has changed? Please check all that apply.

- New phone number
 New email
 New address
(check all that apply)

Please list your new phone number.

(xxx-xxx-xxxx)

Please list your new email address.

Please list your new mailing address.

We will start by asking you a few questions about the contraception that you selected at the beginning of the study.

Are you still using the IUD or Implant that you received at the beginning of this study?

- No
- Yes
- I don't know

In the last 4 weeks, have you checked to make sure your IUD is still in place?

- No, I have not
- Yes, I felt my strings myself and confirmed its still there
- Yes, I had a provider check my string
- I tried but was not able to feel my strings

How long do you plan on using the IUD or Implant that you have?

- Less than 1 year
- More than 1 year but less than 2 years
- More than 2 years but less than 3 years
- More than 3 years but less than 5 years
- More than 5 years but less than 10 years
- More than 10 years
- Unsure
- I prefer not to answer this question

What are the reasons you are no longer using your IUD or Implant?

- It fell out
- Excessive bleeding
- Cramping
- Pain
- Breast symptoms
- Weight gain
- Moodiness or depression
- Bloating
- Skin problems
- Pain during intercourse
- Partner could feel it
- I wanted to get pregnant
- I had a positive pregnancy test
- Other

If other, please specify:

When was the date the device removed or fell out?

Which of the following best describes your vaginal bleeding in the past 4 weeks?

- I've had no vaginal bleeding
- I've had less bleeding than before the device
- I've had no change from before the device
- I've had more bleeding than before the device

The next questions are about any pregnancy or health issues that may be related to your contraception since you entered the study.

In the last four weeks, have you taken a pregnancy test?

- No
- Yes, I took a test at home
- Yes, I took a test in a clinic
- I don't know

What were the results of your pregnancy test?

- Negative
- Positive
- I don't know

What was the date of your positive pregnancy test?

If you have had a positive pregnancy test, please indicate the outcome of the pregnancy.

- I had or am planning to have an abortion
- I had a miscarriage
- I had an ectopic pregnancy
- I am planning on continuing the pregnancy and keeping the baby
- I am planning on continuing the pregnancy and giving the baby up for adoption
- I am unsure of what I am going to do
- I have not had a positive pregnancy test

What was the date when your pregnancy ended, regardless of the outcome?

To ensure your safety, if you had a pregnancy, we will follow-up on the care you received. Please provide the name of the clinic or hospital where you were seen?

Since enrolling in the study, have you been hospitalized for any illness or injury?

- Yes
- No

Please provide the date:

Please explain what happened:

Have you seen a medical provider for an issue that you thought might be related to the IUD or contraceptive implant you had inserted?

- Yes
- No

Please provide the date:

Please describe:

Now we want to ask you some questions about birth control. Think about the method(s) you have been using in the last 4 weeks.

What method(s) to prevent pregnancy have you used in the last 4 weeks?

- None; I am not using any contraceptive method
- Withdrawal
- Male condom
- Female condom
- Fertility Awareness Method / Natural Family Planning / Rhythm Method
- Cervical cap or sponge
- Spermicide
- Diaphragm
- Oral contraceptive, "The Pill"
- Contraceptive patch (Ortho Evra)
- Vaginal ring (NuvaRing)
- 3 month injection (Depo-Provera)
- 3 year hormonal IUD (Skyla)
- 5 year hormonal IUD (Mirena)
- Non-hormonal copper IUD (Paragard)
- Contraceptive Implant (Nexplanon)
- Sterilization (tied tubes, hysterectomy or male partner has had a vasectomy)
- Emergency contraception (Plan B, Ella, Next Choice, or The Morning After Pill)
- Other
(select all that apply)

If other, please specify: _____

Overall, how satisfied are you with your birth control?

- Completely satisfied
- Somewhat satisfied
- Neither satisfied or dissatisfied
- Somewhat dissatisfied
- Completely dissatisfied
- I prefer not to answer

Overall, how confident are you with your birth control?

- Very high confidence
- High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence
- I prefer not to answer

Please rate your agreement or disagreement with the following statement: "I feel that I have control over whether or not I get pregnant."

- I strongly agree
- I somewhat agree
- I neither agree nor disagree
- I somewhat disagree
- I strongly disagree
- I prefer not to answer

Now we want to ask you a few questions about certain aspects of your health and well-being that may be related to your menstrual cycle. In the past 4 weeks, have any the following health issues been a problem for you?

	Have not had in the past 30 days	Once a month	A couple of days a month	Once a week	A couple of days a week	Everyday	Don't know
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moodiness or irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne flare-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cramping Weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gain Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you sought medical care for any of these conditions?

- Yes
- No
- Don't know

If so, please specify which one(s):

Were you prescribed medication to treat these conditions?

- Yes
- No

Next, we want to gather information about your sexual relationships. Please remember that everything you say is confidential. For these questions, we are interested in your relationships with members of the opposite sex. We recognize some people are in same-sex relationships, but the focus of this study relates to sex between women and men.

Have you been sexually active in the past four weeks?

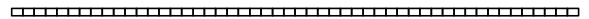
- No
- Yes
- I prefer not to answer

Is this partner the same person you were having sex with when you took the previous survey 4 weeks ago?

- No
- Yes
- I prefer not to answer

On a scale of 1 to 100, how might you rank your sex life right now?

worst possible best possible



(Place a mark on the scale above)

What do you think would have to change to bring it to a 100?

In the last 4 weeks, would you say that your contraceptive method has...

- Made your sex life better
- Made your sex life worse
- Had no effect on my sex life

Please explain the impact your current contraceptive method has on your sex life.

Do you have any concern about your sexual functioning?

- No
- Yes
- I don't know

Please briefly describe.

We will now ask you a few questions about your sexual feelings and responses during the past four weeks. Just do your best to answer each one.

Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?

- Very high
- High
- Moderate
- Low
- Very low or none at all
- Prefer not to answer

Over the past 4 weeks, how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?

- No sexual activity
- Very high
- High
- Moderate
- Low
- Very low or none at all
- Prefer not to answer

Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

Over the past 4 weeks, when you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

Over the past 4 weeks, how satisfied have you been with your overall sexual life?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied
- Prefer not to answer

Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
- Prefer not to answer

The following items relate to your sexual experiences. You might find a few of the items similar to items you just filled out. That's okay; just do your best to answer all the questions. When responding to these items, please think about the last 4 weeks. Thinking about the last month, how satisfied or dissatisfied are you with each of the following issues?

	not at all satisfied	a little satisfied	moderately satisfied	very satisfied	extremely satisfied	I prefer not to answer
The intensity of my sexual arousal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The quality of my orgasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My letting go and surrender to sexual pleasure during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My focus and concentration during sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way I sexually react to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My body's sexual functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My emotional opening up in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My mood after sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The frequency of my orgasms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The pleasure I provide to my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The balance between what I give and receive in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's emotional opening up during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's initiation of sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's ability to orgasm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's surrender to sexual pleasure (letting go)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way my partner takes care of my sexual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's sexual creativity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My partner's sexual availability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The variety of my sexual activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The frequency of my sexual activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The last few items have to do with more general health and well-being. Please think about your experiences in the last four weeks when answering.

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt calm and relaxed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt active and vigorous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I woke up feeling fresh and rested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My daily life has been filled with things that interest me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you again for participating in this study. In the space below, feel free to tell us anything else you wish about your experience with your contraception or participation in this study. Otherwise, we will be in touch with you when it's time for the next part of the study.

Comments:
