PREQUESTIONNAIRE FORM OF ERMA STUDY

When you have familiarized yourself with the material of the Estrogen Regulation of Muscle Apoptosis (ERMA) study, please answer the following questions and return this form together with the consent form. Postage has been paid for the accompanying envelope. The information you provide on this form will be handled with extreme confidentiality.

Please answer the questions below (1–12), based on which we will evaluate your suitability for our study.

Pelvic floor dysfunction is common during the menopause, and it can weaken one’s physical and social functioning. Please also answer the questions related to these symptoms (13), even if a doctor has not diagnosed them.

1. I have had an ovary removal surgery
   a. One ovary has been removed
   b. Both ovaries have been removed

2. I have had a hysterectomy

3. I have a chronic myopathy (a muscle disease diagnosed by a doctor)
   What? ________________________________

4. I have a polycystic ovary disease (diagnosed by a doctor)

5. I have Chrohn’s disease (diagnosed by a doctor)

6. I have used hormonal contraception during the past three months
   The contraception I use is
   - hormonal intrauterine device (IUD)
   - mini-pill or another progestogen-only product
   - combined contraceptive pill
   - vaginal ring
   - contraceptive patch

Please turn over...
7. I currently get hormone replacement therapy for menopause symptoms, prescribed by a doctor (patch, gel or pills)  

Yes   No

8. I am pregnant / breastfeeding

Yes   No

9. My menstrual cycle is regular

Yes   No

My last menstrual bleeding was _______________________________

10. My menstrual cycle is irregular

Yes   No

My last menstrual bleeding was _______________________________

11. My height is _______ cm

12. My weight is _______ kg

13. Pelvic floor dysfunction (based on your own experience or evaluation)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Since when have you had the symptom?</th>
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<tbody>
<tr>
<td>During the past month, have you had urinary incontinence on effort or coughing, etc.?</td>
<td>(x)</td>
<td>(x)</td>
<td>(year)</td>
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<tr>
<td>During the past month, have you had urinary urgency or associated leakage of urine?</td>
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<tr>
<td>During the past month, have you had fecal incontinence?</td>
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<tr>
<td>During the past month, have you had constipation or defecation problems?</td>
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<tr>
<td>During the past month, have you had a feeling that something would be bulging out of your vagina?</td>
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</table>

Please return this form together with the consent form in the accompanying envelope.

Thank you for answering!