Note: you may also email this form to: Heather@CenterForEndo.com

KENNY R. SINERVO, MD FRCSC LLC
Center for Endometriosis Care

A COEMIG-Designated Center of Excellence in Minimally Invasive Gynecologic Surgery
A Center of Expertise in Endometriosis
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POST-SURGICAL FOLLOW-UP QUESTIONNAIRE

YOUR NAME: _____

TODAY'S DATE: _____ DATE OF SURGERY: _____

Please accept our great appreciation for taking your time to complete this important questionnaire. The Center for Endometriosis Care holds one of the largest, ongoing studies evaluating the long-term results of Laparoscopic Excision (LAPEX) for the treatment of endometriosis. Your input allows us to accurately calculate our pain relief success, recurrence and fertility rates over a long period of time. Without you, our accuracy decreases and our intervals of follow-up are shortened. Please help us maintain our study by taking a moment to fill in the details below. Kindly return this form to our offices upon completion. Thank you!

Please write your current contact information (address, phone numbers and email address) here:

Did you have any post-operative complications we are not already aware of? ☐ YES ☐ NO
Please list the diagnosis and treatment:

Since your surgery with us, have you taken any suppressive medications such as Lupron®, Synarel®, Zoladex®, Visanne®, Femara®, Depo Provera®, Mirena® or other? ☐ YES ☐ NO If yes, please list the drug(s) and describe why:

Since your surgery with us, have you had another pelvic surgery for any reason, such as a Laparoscopy or hysterectomy? ☐ YES ☐ NO If yes, please describe the surger(ies) performed and the findings:

If yes to above, was endometriosis found in any of the subsequent procedures? ☐ YES ☐ NO **If yes, please provide us with a copy of the operative report and pathology confirmation by faxing them to 770-913-0005, emailing to Heather@CenterForEndo.com, or by mailing a copy to our offices. Thank you in advance.**

Since your surgery, have you tried to conceive? ☐ YES ☐ NO
If yes, were you able to conceive naturally? ☐ YES ☐ NO
Please tell us the outcome of the pregnancy:

Please rate your quality of life as you are experiencing it NOW, related to any pelvic or abdominal pain:

☐ Awful ☐ Poor ☐ Fair ☐ Good ☐ Terrific

Symptoms you are STILL experiencing:

Slight=does not require any pain medication
Moderate=requires only non-narcotic pain medication
Severe=requires narcotic pain medication
Crippling=keeps you from performing daily tasks or severely limits your activity at least one day per month

Pelvic pain (away from your period)

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Menstrual cramps

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Painful sex with deep penetration

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Painful bowel movements

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Constipation

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Diarrhea

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Intestinal cramping

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Bladder pain

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Pelvic pain with exercise

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Backache

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Pain during pelvic exam

☐ does not apply ☐ slight ☐ moderate ☐ severe ☐ crippling

Other: please let us know what other symptoms you may be experiencing not listed above. Be sure to describe the symptoms along with duration, what works to relieve them (if anything) and other details you'd like us to know.

WOULD YOU BE WILLING TO SERVE AS A REFERENCE FOR THE CENTER FOR ENDOMETRIOSIS CARE?

☐ Yes, please contact me to discuss how I may be of help at _____

☐ No

IS THERE ANYTHING YOU'D LIKE US TO KNOW? Attach additional sheets as needed.

THE COLLECTION OF THIS DATA IS OF UTMOST IMPORTANCE TO FUTURE ENDOMETRIOSIS PATIENTS AND THE DOCTORS WHO WILL TREAT THEM. IT TAKES YEARS TO COLLECT VALID INFORMATION REGARDING THE LONG-TERM RESULTS OF SURGERY. WE HAVE BEEN VERY FORTUNATE TO TAKE CARE OF SO MANY WONDERFUL INDIVIDUALS, WHO HAVE SUFFERED SO MUCH AT THE HANDS OF THIS DISEASE; NOW WE NEED TO BE SURE THAT EVERYONE IS INCLUDED IN THE FOLLOW-UP. PLEASE LET US MAKE COPIES OF YOUR RECORDS BY SIGNING THE FOLLOWING RELEASE. THANK YOU FOR THE TIME YOU WILL SPEND DOING THIS.

RELEASE

FOR THE PURPOSES OF SCIENTIFIC RESEARCH, I AUTHORIZE RELEASE OF COPIES OF ANY MEDICAL INFORMATION INCLUDING OPERATIVE REPORTS, VIDEOTAPES, PATHOLOGY REPORTS AND OTHER MEDICAL RECORDS TO KENNY R. SINERVO, MD, FRCSC, LLC / THE CENTER FOR ENDOMETRIOSIS CARE: PERIMETER TOWN CENTER, 1140 HAMMOND DRIVE, BUILDING F, SUITE 6220, ATLANTA, GA 30328.

SIGNED: _____

DATED: _____