



**Note: you may also email this form to: [Heather@CenterForEndo.com](mailto:Heather@CenterForEndo.com)**

**The Center for Endometriosis Care**  
**Kenny Sinervo MD FRCSC, LLC**  
 A COEMIG-Designated Center of Excellence in Minimally Invasive  
 Gynecology & Center of Expertise in Endometriosis  
**Medical Director Ken R. Sinervo MD, MSC, FRCSC, ACGE**  
 Nicholas Kongoasa, MD, FACOG, Surgeon  
 Robert B. Albee Jr. MD, FACOG, ACGE, Founder Emeritus



## 6+ MONTH POST-SURGICAL FOLLOW-UP QUESTIONNAIRE

YOUR NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

DATE OF SURGERY: \_\_\_\_\_  
*(should be at least 6 months post-op)*

*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](mailto: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.

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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 LIKE YOU, 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, 6105 PEACHTREE DUNWOODY ROAD | BUILDING B, SUITE 230 | ATLANTA, GA 30328

SIGNED: \_\_\_\_\_

DATED: \_\_\_\_\_