



6+ MONTH POST-SURGICAL FOLLOW-UP QUESTIONNAIRE
NOTE: you may also email a copy of this form to Heather@CenterForEndo.com

YOUR NAME: _____

IF DIFFERENT AT TIME OF SURGERY: _____

TODAY'S DATE: _____ DATE OF SURGERY: _____
(must 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, with many of our follow-ups dating back over 25 years. 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 email or 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 histologically confirmed 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/Cramping (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. Attach additional sheets if needed.

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 _____
- Not at this time

IS THERE ANYTHING ELSE 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: _____