SJLIFE

Women's Health Questionnaire

The following questionnaire addresses personal subject matter on topics including fertility, puberty, and sexual health/functioning. These important quality of life issues have not been well studied among survivors of childhood cancer. By completing this questionnaire, you will help us better understand these issues which could one day lead to improved prevention and treatment options.

All adult SJLIFE participants are being asked to complete this questionnaire. Be assured that your participation is voluntary and you may choose to answer all, some, or none of the questionnaire items. Your responses will be kept confidential so please do not put *any* identifying information (like name, age, or date of birth) on this questionnaire. Once completed, please seal the questionnaire in the attached envelope and drop it off in the questionnaire box in the SJLIFE clinic. Thank you in advance for your participation.

Today's date: ☐☐ / ☐☐ / ☐☐☐☐

Please! Do not mark below this line

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box.
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided.
5. Once you have completed the questionnaire, please place it in the attached envelope and drop it off in the SJLIFE questionnaire box in clinic.

ESTROGEN THERAPY

Estrogen is the female hormone made by the ovaries. It can be given to patients to start puberty (puberty is defined as the physical changes that allow a girl's body to change into a woman's body) or can be used in older females who have low blood levels of estrogen. Estrogen can also be used with other female hormones as a form of birth control.

A1. Have you ever been treated with estrogen?

- ☐ Yes
- ☐ No → *Go to Question B1, next page.*
- ☐ I don't know

A2. Were you treated with estrogen therapy during puberty (puberty in girls is typically around ages 10-11 and leads to increase in size of breasts and development of pubic hair)?

- ☐ Yes
- ☐ No
- ☐ I don't know

A3. Were you treated with estrogen to prevent signs and symptoms of menopause (hot flashes, vaginal dryness, bone loss and/or decreased sex drive)?

- ☐ Yes
- ☐ No
- ☐ I don't know

A4. Were you treated with estrogen or other hormones to prevent pregnancy?

- ☐ Yes
- ☐ No
- ☐ I don't know

A5. Was your treatment with estrogen...

- ☐ continuous
- ☐ interrupted (stopped and started again)

A6. How many years (in total) have you been on estrogen? Do not count years in which your estrogen therapy was stopped.

☐☐ Years

A7. Are you currently on estrogen?

☐ Yes

☐ No

A8. How have you received estrogen treatments? *(Mark all that apply)*

☐ Injections (shots) ☐ Skin patch

☐ Pills ☐ Vaginal ring

☐ Gel/Cream

A9. At what age did you start estrogen?

☐☐ Age in years

A10. If you took estrogen and it was discontinued, at what age did you last stop taking estrogen?

☐☐ Age in years

A11. If you stopped taking estrogen, why did you stop? *(Mark all that apply)*

☐ I stopped the medicine because I did not like taking it

☐ My doctor told me to stop

☐ I no longer had a prescription for the medicine

☐ Other reason

If Other reason, explain.

BODY IMAGE

On this scale you will be asked how you feel about your appearance, and about any changes that may have resulted from your disease or treatment. Please read each item carefully, and mark the response which comes closest to the way you have been feeling about yourself during the past week.

During the past week	Not at all	A little	Quite a bit	Very much
B1. Have you been feeling self-conscious about your appearance?	☐	☐	☐	☐
B2. Have you felt less physically attractive as a result of your disease or treatment?	☐	☐	☐	☐
B3. Have you been dissatisfied with your appearance when dressed?	☐	☐	☐	☐
B4. Have you been feeling less feminine as a result of your disease or treatment?	☐	☐	☐	☐
B5. Have you been finding it difficult to look at yourself naked?	☐	☐	☐	☐
B6. Have you been feeling less sexually attractive as a result of your disease or treatment?	☐	☐	☐	☐
B7. Have you been avoiding people because of the way you felt about your appearance?	☐	☐	☐	☐
B8. Have you been feeling the treatment has left your body less whole?	☐	☐	☐	☐
B9. Have you felt dissatisfied with your body?	☐	☐	☐	☐
B10. Have you been dissatisfied with the appearance of a scar(s)?	☐	☐	☐	☐

B11. At the present time, do you have any of the following?	No	Yes
Persistent hair loss	☐	☐
Scarring or disfigurement of the head or neck region (including the face)	☐	☐
Scarring or disfigurement of the chest or abdominal region	☐	☐
Scarring or disfigurement of the arms or legs (including an abnormally short arm or leg)	☐	☐
Walk with a limp	☐	☐
Loss of an arm or a leg	☐	☐
Loss of an eye	☐	☐
Other	☐	☐

If Other, specify.

Please! Do not mark below this line

PERCEPTIONS

It is common for people to have different ideas about their own chances of experiencing certain medical problems. Please answer the next few questions by marking the answer that best describes your own opinions.

C1. Mark the response that best describes your risk compared to other women your age never diagnosed with cancer or a disease like cancer.

	Much more	Slightly more	About the same	Slightly less	Much less
a. Infertility	☐	☐	☐	☐	☐
b. Sexual dysfunction	☐	☐	☐	☐	☐
c. Low estrogen levels	☐	☐	☐	☐	☐

If you answered *Slightly more* or *Much more* to any of the medical problems listed above, continue with the next question. Otherwise, skip to Question D1, next page.

C2. If you think you have increased risk (you answered *Slightly more* or *Much more* in Question D1) for having infertility, sexual dysfunction, or low estrogen due to cancer or a similar illness, please mark the reasons from the choices below. If you do not feel that you are at increased risk for a medical problem, mark "Not applicable".

I think I am at increased risk because of . . .
(Mark all that apply)

	The kind of surgery I needed for my cancer or similar illness	The kind of radiation I received	The kind of chemotherapy I received	The type of cancer or an illness like cancer that I had	Not applicable
a. Infertility	☐	☐	☐	☐	☐
b. Sexual dysfunction	☐	☐	☐	☐	☐
c. Low estrogen levels	☐	☐	☐	☐	☐

C3. If you consider yourself at risk for infertility, sexual dysfunction, and/or low estrogen, how did you learn of your increased risk?
(Mark all that apply)

	Another way	Information you found on the internet	Printed information	Your gynecologist	Your general practitioner/internist	Your family	Your oncologist	Not applicable
a. Infertility	☐	☐	☐	☐	☐	☐	☐	☐
b. Sexual dysfunction	☐	☐	☐	☐	☐	☐	☐	☐
c. Low estrogen levels	☐	☐	☐	☐	☐	☐	☐	☐

If another way, please specify.

C4. If told by a healthcare professional about potential problems with fertility, sexual functioning, and/or low estrogen, when did you receive the information?
(Mark all that apply)

	After treatment in another setting	After treatment in a long-term follow-up program/ cancer survivor program	After treatment, by your oncologist	At the time of treatment	At the time of diagnosis	Not applicable
a. Infertility	☐	☐	☐	☐	☐	☐
b. Sexual dysfunction	☐	☐	☐	☐	☐	☐
c. Low estrogen levels	☐	☐	☐	☐	☐	☐

If in another setting, please specify.

Please! Do not mark below this line

RELATIONSHIP/MARITAL SATISFACTION SCALE

D1. Are you <u>currently</u> married or in a significant relationship?

☐ Yes

☐ No → *Go to Question E1.*

Please mark the number for each item which best answers that item for you.

D2. How well does your partner meet your needs?

1	2	3	4	5
☐	☐	☐	☐	☐
Poorly		Average		Extremely well

D3. In general, how satisfied are you with your relationship?

1	2	3	4	5
☐	☐	☐	☐	☐
Unsatisfied		Average		Extremely satisfied

D4. How good is your relationship compared to most?

1	2	3	4	5
☐	☐	☐	☐	☐
Poor		Average		Excellent

D5. How often do you wish you hadn't gotten into this relationship?

1	2	3	4	5
☐	☐	☐	☐	☐
Never		Average		Very often

D6. To what extent has your relationship met your original expectations?

1	2	3	4	5
☐	☐	☐	☐	☐
Hardly at all		Average		Completely

D7. How much do you love your partner?

1	2	3	4	5
☐	☐	☐	☐	☐
Not much		Average		Very much

D8. How many problems are there in your relationship?

1	2	3	4	5
☐	☐	☐	☐	☐
Very few		Average		Very many

FERTILITY AND FERTILITY PRESERVATION

The next set of questions will ask about your fertility, pubertal development, sexual development, and quality of life. You may feel these questions are personal. Please be reassured your responses will remain confidential.

E1. Do you know your fertility status?

☐ Yes

☐ No

E2. Have you and a partner ever <u>tried</u> to become pregnant?

☐ Yes

☐ No → *Go to Question E12, next page.*

E3. Have you ever had difficulty (it took more than 1 year) becoming pregnant with a partner?

☐ Yes

☐ No

☐ I don't know

E4. Were you able to have all the children you wanted to have?

☐ Yes → *Go to Question E6, next page.*

☐ No

E4a. *If no*, which of you wanted more children?

☐ I wanted more children but my partner(s) did not

☐ My partner(s) wanted more children but I did not

☐ We both wanted more children but we could not have more

Please! Do not mark below this line

E5. If more children were wanted, what were the reasons for not having more children? *(Mark all that apply)*

- ☐ I was unable to have more children (female infertility)
- ☐ I had other health issues related to my cancer treatment that made us decide not to have more children
- ☐ I had other health issues not related to my cancer treatment that made us decide not to have more children
- ☐ My partner was not able to help me conceive (male infertility)
- ☐ My partner had other health issues that made us decide not to have more children
- ☐ My partner and I tried but could not become pregnant, we do not know the reason why
- ☐ There were issues other than health that kept us from having more children (social/financial)

If there were other issues, please specify.

E6. Have you or a male partner ever been evaluated for infertility?

- ☐ Yes
- ☐ No → *Go to Question E10.*
- ☐ I don't know

E7. If you or your partner were evaluated for decreased fertility, was a problem identified?

- ☐ Yes. A fertility problem was found in my partner.
- ☐ Yes. A fertility problem was found in me.
- ☐ Yes. A fertility problem was found in both me and my partner.
- ☐ No
- ☐ I don't know

E8. Were you personally evaluated by a fertility specialist?

- ☐ Yes
- ☐ No → *Go to Question E10.*

If yes, which kind of physician?

If yes, how old were you at the time of evaluation? ☐☐ **Age in years**

E9. If you were evaluated by a fertility specialist, was a problem identified?

- ☐ Yes
- ☐ No

If yes, please specify.

E10. Have you/your partner engaged in treatment for fertility problems?

- ☐ Yes
- ☐ No → *Go to Question E12.*

E11. *If yes*, what type of treatment? *(Mark all that apply)*

- ☐ Insemination
- ☐ Ovulation Drugs
- ☐ In Vitro Fertilization (IVF)
- ☐ Other

If Other, please specify.

E12. Do you have any concerns about your fertility (your ability to have/produce biological children in the future)?

- ☐ No
- ☐ Yes
- ☐ Not sure

E13. Were you/are you at risk for premature ovarian failure (early menopause) due to cancer treatment?

☐ Yes ☐ No ☐ I don't know

E14. Did you undergo oocyte cryopreservation (egg freezing) before you received cancer therapy?

☐ Yes ☐ No ☐ I don't know

E15. Did you undergo oocyte cryopreservation (egg freezing) after you received cancer therapy?

☐ Yes ☐ No ☐ I don't know

E16. Did you undergo ovarian tissue freezing/cryopreservation before you started cancer treatment?

☐ Yes ☐ No ☐ I don't know

Please! Do not mark below this line

E17. Regardless of what you decided, were you offered fertility preservation before, during, or after your cancer treatment? *(Mark all that apply)*

- ☐ No
- ☐ Yes, before treatment
- ☐ Yes, during treatment
- ☐ Yes, after treatment

PUBERTY AND SEXUAL DEVELOPMENT

F1. Was the onset of your puberty . . . *(The onset of puberty in females is characterized by pubic hair and breast development.)*

- ☐ Early compared to others your age
- ☐ Normal compared to others your age
- ☐ Late compared to others your age

F2. Were hormones needed to start your puberty?

- ☐ Yes
- ☐ No

F3. Have you had sexual intercourse?

- ☐ Yes
- ☐ No → ***If no, Go to Question F6.***

If yes, at what age did you first have intercourse?

☐☐

Age in years

F4. Did you or your partner use a condom at last intercourse?

- ☐ No
- ☐ Yes → ***Go to Question F5.***

F4a. If you did not use a condom at last intercourse, what method did you or your partner use to prevent pregnancy? ***(Select only one response.)***

- ☐ No method was used to prevent pregnancy
- ☐ Birth control pills
- ☐ IUD (such as Mirena or ParaGard)
- ☐ Implant (such as Implanon or Nexplanon)
- ☐ Shot (such as Depo-Provera)
- ☐ Birth control patch (such as Ortho Evra)
- ☐ Birth control ring (such as NuvaRing)
- ☐ Sponge (such as Today Sponge)
- ☐ Spermicide
- ☐ Withdrawal or some other method

F5. In general, how often do you or your partner use a condom during sex? ***(Select only one response.)***

- ☐ Not applicable because I have never had sex
- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

F6. My previous sexual experiences have been with . . . ***(Mark all that apply)***

- ☐ The opposite gender - men
- ☐ The same gender - women
- ☐ Both genders- men and women
- ☐ Myself- I have masturbated
- ☐ None of the above
- ☐ No reply

F7. My sexual experiences in the last year have been with . . . ***(Mark all that apply)***

- ☐ The opposite gender - men
- ☐ The same gender - women
- ☐ Both genders- men and women
- ☐ Myself- I have masturbated
- ☐ None of the above
- ☐ No reply

F8. How many sexual partners have you had in the last month?

☐☐

F9. How many sexual partners have you had in the last year?

☐☐

F10. How many sexual partners have you had in your lifetime?

☐☐

Please! Do not mark below this line

SEXUAL ACTIVITY

The following are questions commonly used by doctors to assess sexual function in females. They are standardized questions asked in a standardized fashion.

These next questions are sensitive and personal. They are very important in understanding how your medical illness or treatment affects your self and your body. Some questions ask about your own experiences, thoughts, and feelings, while others ask about how treatment has affected your intimate relationships. Please answer each question honestly and accurately. Be assured that your responses are totally confidential.

G1. Have you been sexually active in the <u>past year</u> (alone or with a partner)?

- ☐ Yes → ***Go to Question G3.***
- ☐ No

G2. I have not been sexually active in the <u>last year</u> because . . . *(Mark all that apply)*

- ☐ I have never been sexually active → ***Go to Question G4.***
- ☐ I am too tired
- ☐ I am not interested
- ☐ I have a physical problem that makes sexual relations difficult or uncomfortable
- ☐ My partner is not interested
- ☐ My partner is too tired
- ☐ My partner has a physical problem that makes sexual relations difficult or uncomfortable
- ☐ Other

If Other, please specify.

G3. Have you been sexually active in the <u>past month</u> (alone or with a partner)?

- ☐ Yes
- ☐ No

G4. In the <u>past month</u>, how frequently have you had sexual thoughts, urges, fantasies, or erotic dreams? ***(Please mark the one item that is closest to your experience.)***

- ☐ Not at all
- ☐ Once
- ☐ 2 or 3 times
- ☐ Once a week
- ☐ 2 or 3 times a week
- ☐ Once a day
- ☐ More than once a day

G5. Using the scale below, how frequently have you felt an interest or desire to engage in the following specific activities in the <u>past month</u>?

(This question is about your desire to engage, <u>not</u> about how you feel during sexual activity.)

(For each item, please mark the response that is closest to your experience):

	Not at all	Once	2 to 3 times	Once a week	2 to 3 times per week	Once a day	More than once a day
a. Dreams or fantasy	☐	☐	☐	☐	☐	☐	☐
b. Masturbation	☐	☐	☐	☐	☐	☐	☐
c. Touching, hugging, holding, kissing	☐	☐	☐	☐	☐	☐	☐
d. Petting or foreplay	☐	☐	☐	☐	☐	☐	☐
e. Vaginal intercourse	☐	☐	☐	☐	☐	☐	☐
f. Other sexual activity	☐	☐	☐	☐	☐	☐	☐

If Other, please specify.

Please! Do not mark below this line

G6. How frequently have you become aroused by the following sexual activity in the past month?

(By arousal, we mean the physical and emotional responses in your body and mind that tell you that you are feeling sexual.)

(For each item, please mark the response that is closest to your experience):

	Not at all	Once	2 to 3 times	Once a week	2 to 3 times per week	Once a day	More than once a day
a. Dreams or fantasy	☐	☐	☐	☐	☐	☐	☐
b. Masturbation	☐	☐	☐	☐	☐	☐	☐
c. Touching, hugging, holding, kissing	☐	☐	☐	☐	☐	☐	☐
d. Petting or foreplay	☐	☐	☐	☐	☐	☐	☐
e. Vaginal intercourse	☐	☐	☐	☐	☐	☐	☐
f. Other sexual activity	☐	☐	☐	☐	☐	☐	☐

If Other, please specify.

G7. In the past month, have you felt pleasure from any sexual activity?

- ☐ I have had no sexual activity in the past month
- ☐ I have not felt any pleasure
- ☐ Seldom, less than 25% of the time
- ☐ Sometimes, about 50% of the time
- ☐ Usually, about 75% of the time
- ☐ Always felt pleasure

G8. Using the scale below, how frequently have you engaged in the following activities in the past month?

(For each item, please mark the response that is closest to your experience):

	Not at all	Once	2 to 3 tim	Once a week	2 to 3 times per week	Once a day	More than once a day
a. Dreams or fantasy	☐	☐	☐	☐	☐	☐	☐
b. Masturbation	☐	☐	☐	☐	☐	☐	☐
c. Touching, hugging, holding, kissing	☐	☐	☐	☐	☐	☐	☐
d. Petting or foreplay	☐	☐	☐	☐	☐	☐	☐
e. Masturbation with partner	☐	☐	☐	☐	☐	☐	☐
f. Vaginal intercourse	☐	☐	☐	☐	☐	☐	☐
g. Other sexual activity	☐	☐	☐	☐	☐	☐	☐

If Other, please specify.

G9. In the past month, how often have you reached orgasm (climax) during sexual activity?

- ☐ I have had no sexual activity in the last month
- ☐ I have not experienced orgasm
- ☐ Seldom, less than 25% of the time
- ☐ Sometimes, about 50% of the time
- ☐ Usually, about 75% of the time
- ☐ I always experienced orgasm

G10. When you have orgasms (climax), how intense have they been in the past month?

- ☐ I have had no sexual activity in the last month
- ☐ I have had no orgasms in the last month
- ☐ My orgasms were very mild
- ☐ My orgasms were fairly mild
- ☐ My orgasms were fairly strong
- ☐ My orgasms were very strong

Please! Do not mark below this line

G11. How easy or difficult has it been for you to have orgasms (climax) in the past month?

- ☐ I have had no sexual activity in the last month
- ☐ I have had no orgasms in the last month
- ☐ It was very difficult to have orgasms; it took a long time and a lot of concentration
- ☐ It was fairly difficult; it took a while
- ☐ It was fairly easy
- ☐ It was very easy

G12. How frequently in the past month have you had the problems listed below?
ALSO, MARK THE BOX IN THE LAST COLUMN if the problem stops your sexual activity.

	Not at all	Seldom, less than 25% of the time	Sometimes, about 50% of the time	Usually, about 75% of the time	Always	Does the problem stop your current sexual activity? Yes	No
a. Vaginal dryness during sexual activity	☐	☐	☐	☐	☐	☐	☐
b. Lack of sexual interest or desire	☐	☐	☐	☐	☐	☐	☐
c. Vaginal tightness	☐	☐	☐	☐	☐	☐	☐
d. Pain during penetration or intercourse	☐	☐	☐	☐	☐	☐	☐
e. Anxiety about your sexual performance	☐	☐	☐	☐	☐	☐	☐
f. Unable to orgasm	☐	☐	☐	☐	☐	☐	☐
g. Vaginal bleeding or irritation from penetration or intercourse	☐	☐	☐	☐	☐	☐	☐
h. Increased sensitivity of your skin to intimate touching	☐	☐	☐	☐	☐	☐	☐
i. Sharp pain inside or outside your vagina	☐	☐	☐	☐	☐	☐	☐
j. Other problem with sexuality	☐	☐	☐	☐	☐	☐	☐

If Other, please specify.

G13. Please rate how interested you have been in sexual thoughts, feelings, or actions in the past month by marking a number from 0 to 10 (0=Not at all interested, 10=Extremely interested).

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Not at all Interested — Extremely Interested

G14. Please rate the extent to which sexual activity has been satisfying for you in the past month by marking a number from 0 to 10 (0=Not at all satisfying, 10=Extremely satisfying).

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Not at all Satisfying — Extremely Satisfying

G15. How often did the following factors influence your sexual activity in the past month?

	I have not had a partner	Not at all	Seldom, less than 25% of the time	Sometimes, about 50% of the time	Usually, about 75% of the time	Always
a. My own health	☐	☐	☐	☐	☐	☐
b. My partner's health	☐	☐	☐	☐	☐	☐
c. Conflict in my relationship	☐	☐	☐	☐	☐	☐
d. Other	☐	☐	☐	☐	☐	☐

If Other, please specify.

G16. Are you currently in a married or partner relationship that could be sexual?

- ☐ NO, I do not have a possible partner → *Go to Question H1, next page.*
- ☐ YES, I am married or have a partner, and we HAVE been sexually active this past year
- ☐ YES, I am married or have a partner, but we HAVE NOT been sexually active this past year

G17. Over the past 4 weeks, how frequently have you been able to communicate your sexual desires or preferences to your partner?

- ☐ I have been unable to communicate my desires or preferences
- ☐ Seldom, less than 25% of the time
- ☐ Sometimes, about 50% of the time
- ☐ Usually, about 75% of the time
- ☐ I was always able to communicate my desires or preferences

Please! Do not mark below this line

For each item, please mark the response that is closest to your experience:

	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
G18. Overall, how satisfied have you been with your sexual relationship with your partner? . .	☐	☐	☐	☐	☐
G19. Over the past 4 weeks, how satisfied have you been with your sexual relationship with your partner?	☐	☐	☐	☐	☐
G20. Overall, how satisfied do you think your partner has been with your sexual relationship?	☐	☐	☐	☐	☐
G21. Over the past 4 weeks, how satisfied do you think your partner has been with your sexual relationship?	☐	☐	☐	☐	☐

G22. Over the <u>past 4 weeks</u>, please rate how satisfied you have been with your ability to share warmth and intimacy with your partner by marking a number below from 0 to 10 (0=Not at all satisfied, 10=Extremely satisfied).

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

Not at all Satisfied — Extremely Satisfied

G23. Over the <u>past 4 weeks</u>, please rate how comfortable you have been with touching, hugging or holding your partner by marking a number from 0 to 10 (0=Not at all comfortable, 10=Extremely comfortable).

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

Not at all Comfortable — Extremely Comfortable

G24. I feel positive about my sexual relationship?

- ☐ Not in a sexual relationship
- ☐ Rarely or none of the time
- ☐ Some or a little bit of the time
- ☐ Occasionally or a moderate amount of time
- ☐ All of the time

G25. I feel depressed about symptoms that keep me from enjoying sexual activity?

- ☐ Rarely or none of the time
- ☐ Some or a little bit of the time
- ☐ Occasionally or a moderate amount of time
- ☐ All of the time

G26. I sometimes feel too distressed to engage in sexual activity?

- ☐ Rarely or none of the time
- ☐ Some or a little bit of the time
- ☐ Occasionally or a moderate amount of time
- ☐ All of the time

G27. Problems with my sexual performance cause me distress?

- ☐ Rarely or none of the time
- ☐ Some or a little bit of the time
- ☐ Occasionally or a moderate amount of time
- ☐ All of the time

<u>Sexual Dysfunction Therapy</u>

H1. Have you <u>ever</u> received medical treatment for sexual dysfunction like vaginal dryness, itching, or pain (not infection-related) during sex?

- ☐ Yes
- ☐ No

If yes, what medicine(s)?

H2. Have you <u>ever</u> tried/received complementary or alternative medical treatment (herbal supplements or acupuncture, for example) for sexual dysfunction?

- ☐ Yes
- ☐ No

If yes, what treatment(s)?

H3. Have you <u>ever</u> had psychological treatment (talk therapy) for issues related to sexual dysfunction?

- ☐ Yes
- ☐ No

Please! Do not mark below this line

Finally a few questions about how you think survivors of childhood cancer and similar illnesses could best be informed about their risk (if any) of sexual dysfunction.

I1. Is there anything you wish you had been told at the time of your diagnosis and treatment regarding your future fertility or sexual functioning? (use additional pages if necessary)

I2. Is there anything you wish you had been told in a follow up cancer visit regarding your future fertility or sexual functioning? (use additional pages if necessary)

I3. Is there anything you wish to know now regarding fertility or sexual functioning? (use additional pages if necessary)

We are always interested in your input.

Use this space for any additional comments you may have:

Thank you for participating.

Please! Do not mark below this line