VIA MEDICA

SUPPLEMENT

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SUPPLEMENT 1.

MALE QUESTIONNAIRE

Version: 1.0

Study: **Reproductive health in childhood cancer survivors**

Partcipant identification number: XXXXX

Please fill in this questionnaire, check the answer box as shown or write your text.: Example ☒

1. Do you feel sexual desire?
   ☐ Yes ☐ Low ☐ No
2. Do you get an erection?
   ☐ Yes ☐ Not completely ☐ No
3. Are you able to insert yuor penis into vagina ?
   ☐ Yes ☐Not always ☐ No ☐ Have not tried
4. Are you able to get an ejaculation?
   ☐ Yes ☐ Yes, but with difficulties ☐ No
5. What is your current marital status?
   ☐ Married/Have a partner ☐ Divorced ☐ Single ☐ Widowed
6. What is the frequency of your sexual activity ?
   ☐ None
   ☐ I have sexual intercourse.....times per week / ..... times per month
   ☐ I masturbate.....times per week / ..... times per month
7. Do you use contraceptives?
   ☐ Yes ☐ No

- If yes, which ones?
  ☐ contraception is used by my partner
  ☐ condoms
  ☐ *coitus interruptus*

8. Do you have your biological children?
   ☐ Yes ☐ No
   • If yes, how many? .....
9. Are your biological children healthy?
   ☐ Yes ☐ No
   • If no, what is the illness? .....
10. How long did it take for you and your wife/partner to get pregnant?
    .....months .....years
11. Has any of your partners been pregnant with your child
    ☐ Yes ☐ No
12. Has your current partner been pregnant/has children with other partner?
    ☐ Yes ☐ No ☐ I do not know
13. Are you trying to conceive at the moment?
    ☐ Yes…….months ☐ No
14. Have you ever underwent semen analysis?
    ☐ Yes ☐ No

15. Have you consulted a specialist for fertility problems?
☐ Yes ☐ No
16. What diseases/conditions did you have?
☐ Complicated chickenpox, measles, or mumps
☐ I use medication constantly at the current time
☐ Sexual transmitted diseases
☐ Surgery for undescended testicles, testicular torsion or inguinal hernia
☐ Radiotherapy treatment during adulthood (after turning 18 years)
☐ Chemotherapy treatment during adulthood (after turning 18 years)
17. What is your current libido/sexual desire (circle the number)?
(none) 0 1 2 3 4 5 6 7 8 9 10 (very high)
18. Have your blood relatives ever had any fertility problems (grandfather, father, brother, cousin)?
☐ Yes ☐ No

If you have any questions or comments, please, write them on the other side of the questionnaire.

Thank you for your answers!

FEMALE QUESTIONNAIRE

Version: 1.0

Study: **Reproductive health in childhood cancer survivors**

Partcipant identification number: XXXXX

Please fill in this questionnaire, check the answer box as shown or write your text.: Example ☒

1. Do you consider your puberty delayed as compared with the peers?
☐ Yes ☐ No ☐ I do not know
2. Do you consider your puberty delayed as compared with the peers?
☐ Yes ☐ No ☐ I do not know
3. Did you receive chemotherapy after turning 18 years?
☐ Yes ☐ No
• If yes, for what reason? .....
4. Did you receive radiotherapy after turning 18 years?
☐ Yes ☐ No
• If yes, for what reason? .....
5. How old were you when you had your first menstruations?
.....
6. Is your menstrual cycle regular?
☐ Yes ☐ No ☐ No menstrual bleeding
7. What is your current marital status?
☐ Married/Have a partner ☐ Divorced ☐ Single ☐ Widowed
8. Have you ever been pregnant?
☐ Yes ☐ No
If yes, how many times? .....
9. How long did it take for you and your husband/partner to conceive?
..... months ..... years
10. Do you use contraception?
☐ Yes ☐ No
• If yes, which one?
☐ hormonal contraception (pills, patch, ring, uterine device ~~spiral~~)
☐ condoms
☐ *coitus interruptus*
11. Does your current partner have children with his previous partner?
☐ Yes ☐ No ☐ Did not have other partner

Year	Result	Weeks of pregnancy	Birth weight (kg)
	Delivery/Miscarriage		
	Delivery /Miscarriage		
	Delivery /Miscarriage		

12. Have you ever had any problems with your fertility?
    ☐ Yes ☐ No
    • If yes, have you had these gynecological problems
    ☐ Sexually transmitted diseases (*Gonorrhea, Chlamydiosis, Syphilis, Trichomonas vaginalis* infection, H*erpes genitalis* or genital warts, *Mycoplasma* or *Ureaplasma* infection)
    ☐ Surgeries/procedures of cervix
    ☐ Surgeries of uterus or ovaries
    ☐ Pelvic adhesion
    ☐ Pelvic inflammatory disease
    ☐ Polycystic ovarian syndrome
    ☐ Endometriosis
    ☐ Uterine leiomyomas/ fibroids
    ☐ Absent /Disappeared menstrual bleeding
13. Have you been treated for infertility?
    ☐ Yes ☐ No
14. Have you been treated with replacement hormonal therapy?
    ☐ Yes ☐ No
15. Do you currently take any medication constantly?
    ☐ Yes ☐ No
    Is yes, what medication? .....
16. What is the frequency of your sexual activity?
    ☐ None
    ☐ I have.....times per week / ..... times per month
17. What is your current libido (circle the number)?
    (none) 0 1 2 3 4 5 6 7 8 9 10 (very high)
18. Have your relatives (sister, mother, grandmother) ever had any fertility problems?
    ☐ Yes ☐ No

If you have any questions or comments, please, write them on the other side of the questionnaire.
Thank you for your answers!