



University of Oxford



National Endometriosis Society

## The Endometriosis Health Profile Questionnaire (EHP 30)

© Nuffield Department of Obstetrics & Gynaecology  
& Health Services Research Unit  
University of Oxford

In collaboration with The National Endometriosis Society

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- *This questionnaire has been developed to measure the effect endometriosis has upon a woman's quality of life.*
  - *Please answer all the questions.*
  - *We are aware that you may have had endometriosis for a long time. We also understand that how you feel now may be different to how you have felt in the past. However, please would you answer the questions only in relation to the effect that endometriosis has had on your life **during the last 4 weeks**.*
  - *There are no right or wrong answers, so please tick the answers which best represent your feelings and experiences.*
  - *Due to the personal nature of some of the questions please understand that you do not have to answer any questions if you would prefer not to.*
  - *The information and answers you give will be treated with the utmost confidentiality.*
  - *If you have any problems or would like any help or assistance with the completion of this questionnaire please contact Mrs Gill Spencer-Webb (01865 225208) who will be happy to help you.*
  - *Once you have completed the questionnaire please could you return it in the pre-paid envelope provided.*
  - *We would like to thank you very much in anticipation for taking the time to help us with this important research and we look forward to receiving your answers.*
  - *This research is being funded with an educational grant from Pharmacia, USA.*
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## PART 1: CORE QUESTIONNAIRE

DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....

	Never	Rarely	Sometimes	Often	Always
1. Been unable to go to social events because of the pain?	<input type="checkbox"/>				
2. Been unable to do jobs around the home because of the pain?	<input type="checkbox"/>				
3. Found it difficult to stand because of the pain?	<input type="checkbox"/>				
4. Found it difficult to sit because of the pain?	<input type="checkbox"/>				
5. Found it difficult to walk because of the pain?	<input type="checkbox"/>				
6. Found it difficult to exercise or do the leisure activities you would like to do because of the pain?	<input type="checkbox"/>				
7. Lost your appetite and/or been unable to eat because of the pain?	<input type="checkbox"/>				

Please check that you have ticked *one box for each question*  
before moving onto the next page

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
8. Been unable to sleep properly because of the pain?	<input type="checkbox"/>				
9. Had to go to bed/lie down because of the pain?	<input type="checkbox"/>				
10. Been unable to do the things you want to do because of the pain?	<input type="checkbox"/>				
11. Felt unable to cope with the pain?	<input type="checkbox"/>				
12. Generally felt unwell?	<input type="checkbox"/>				
13. Felt frustrated because your symptoms are not getting better?	<input type="checkbox"/>				
14. Felt frustrated because you are not able to control your symptoms?	<input type="checkbox"/>				

Please check that you have ticked *one box for each question*  
before moving onto the next page

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
15. Felt unable to forget your symptoms?	<input type="checkbox"/>				
16. Felt as though your symptoms are ruling your life?	<input type="checkbox"/>				
17. Felt your symptoms are taking away your life?	<input type="checkbox"/>				
18. Felt depressed?	<input type="checkbox"/>				
19. Felt weepy/tearful?	<input type="checkbox"/>				
20. Felt miserable?	<input type="checkbox"/>				
21. Had mood swings?	<input type="checkbox"/>				
22. Felt bad tempered or short tempered?	<input type="checkbox"/>				

Please check that you have ticked ***one box for each question***  
before moving onto the next page

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
23. Felt violent or aggressive?	<input type="checkbox"/>				
24. Felt unable to tell people how you feel?	<input type="checkbox"/>				
25. Felt others do not understand what you are going through?	<input type="checkbox"/>				
26. Felt as though others think you are moaning?	<input type="checkbox"/>				
27. Felt alone?	<input type="checkbox"/>				
28. Felt frustrated as you cannot always wear the clothes you would choose?	<input type="checkbox"/>				
29. Felt your appearance has been affected?	<input type="checkbox"/>				
30. Lacked confidence?	<input type="checkbox"/>				

Please check that you have ticked *one box for each question*  
before moving onto Part 2

## Part 2: MODULAR QUESTIONNAIRE

**Section A:** These questions concern the effect endometriosis has had on your work **during the last 4 weeks**.

If you have not been in paid or voluntary employment during the last 4 weeks please tick here  and move onto Section B.

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
1. Had to take time off work because of the pain?	<input type="checkbox"/>				
2. Been unable to carry out duties at work because of the pain?	<input type="checkbox"/>				
3. Felt embarrassed about symptoms at work?	<input type="checkbox"/>				
4. Felt guilty about taking time off work?	<input type="checkbox"/>				
5. Felt worried about not being able to do your job?	<input type="checkbox"/>				

**Section B:** These questions concern the effect endometriosis has had on your relationship with your child/children **during the last 4 weeks**.

If you do not have any children please tick here  and move onto Section C.

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
1. Found it difficult to look after your child/children?	<input type="checkbox"/>				
2. Been unable to play with your child/children?	<input type="checkbox"/>				

Please check that you have *answered each section* before moving onto the next page

**Section C:** These questions concern the effect endometriosis has had on your sexual relationships during the last 4 weeks.

If you do not wish to answer, please tick here  and move onto Section D.

HOW OFTEN DURING THE LAST 4 WEEKS  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....

	Never	Rarely	Sometimes	Often	Always
1. Experienced pain during or after intercourse? <i>If not relevant please tick here</i> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Felt worried about having intercourse because of the pain? <i>If not relevant please tick here</i> <input type="checkbox"/>	<input type="checkbox"/>				
3. Avoided intercourse because of the pain? <i>If not relevant please tick here</i> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Felt guilty about not wanting to have intercourse? <i>If not relevant please tick here</i> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Felt frustrated because you cannot enjoy intercourse? <i>If not relevant please tick here</i> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check that you have *answered each section* before moving onto the next page

**Section D:** These questions concern your feelings **during the last 4 weeks** about the medical profession.

If this section is not relevant to you please tick here  and move onto Section E.

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
1. Felt the doctor(s) you have seen is (are) not doing anything for you?	<input type="checkbox"/>				
2. Felt the doctor(s) think it is all in your mind?	<input type="checkbox"/>				
3. Felt frustrated at the doctor(s) lack of knowledge about endometriosis?	<input type="checkbox"/>				
4. Felt like you are wasting the doctor(s) time?	<input type="checkbox"/>				

**Section E:** These questions concern your feelings **during the last 4 weeks** about your treatment for endometriosis. Treatment means any surgery or **prescribed** medication for your endometriosis.

If this question is not relevant to you please tick here  and move onto Section F.

**DURING THE LAST 4 WEEKS HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
1. Felt frustrated because treatment is not working?	<input type="checkbox"/>				
2. Found it difficult coping with the side effects of treatment?	<input type="checkbox"/>				
3. Felt annoyed at the amount of treatment you have had to have?	<input type="checkbox"/>				

Please check that you have *answered each section* before moving onto the next page

**Section F:** These questions concern your feelings **during the last 4 weeks** about any difficulties you might have conceiving.

If this section is not relevant to you please tick here  and move onto Part 3.

**DURING THE LAST 4 WEEKS, HOW OFTEN  
BECAUSE OF YOUR ENDOMETRIOSIS HAVE YOU.....**

	Never	Rarely	Sometimes	Often	Always
1. Felt worried about the possibility of not having children/more children?	<input type="checkbox"/>				
2. Felt inadequate because you may not/have not been able to have children/more children?	<input type="checkbox"/>				
3. Felt depressed at the possibility of not having children/more children?	<input type="checkbox"/>				
4. Felt that the possibility of not conceiving/not being able to conceive has put a strain upon your personal relationship?	<input type="checkbox"/>				

Please check that you have **answered each section** that applies to you before moving onto Part 3

### Part 3: GENERAL DETAILS

In this section, please could you tell us some general details about yourself.....

- |  | Day                                       | Month                                     | Year  |
|--|---|---|---|
| 1. What is your date of birth?   | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 2. What date did you complete this questionnaire?  | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 3. When did you first have symptoms of endometriosis?  |   |   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 4. When was your endometriosis first diagnosed at surgery?   |   |   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 5. Please tick which symptom(s) you have had because of your endometriosis over the last 4 weeks ( <i>you may tick more than one</i> ) |   |   |   |
| a) Pelvic pain unrelated to period pain?   | <input type="checkbox"/>                  |   |   |
| b) Felt sick or vomited?   | <input type="checkbox"/>                  |   |   |
| c) Felt tired/lacking in energy?   | <input type="checkbox"/>                  |   |   |
| d) Pain when passing urine?  | <input type="checkbox"/>                  |   |   |
| e) Pain when opening bowels?   | <input type="checkbox"/>                  |   |   |
| f) Constipation or diarrhoea?  | <input type="checkbox"/>                  |   |   |
| g) Irregular bleeding?   | <input type="checkbox"/>                  |   |   |
| h) Period pain?  | <input type="checkbox"/>                  |   |   |

Note: if you have not had a period during the last 4 weeks please tick here

6. Are you (*please circle as appropriate*)
- a) Single   b) Cohabiting   c) Married   d) Separated   e) Divorced   f) Widowed
7. Please state where you filled in this questionnaire (*please circle as appropriate*)
- a) at home   b) in hospital   c) other (please state).....

Please check that you have **answered each section** that applies to you before moving onto Part 4

## Part 4: General Health Questions

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1. Overall, how would you rate your health during the past 4 weeks?

Excellent	Very good	Good	Fair	Poor	Very Poor
<input type="checkbox"/>					

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2. During the past 4 weeks, how much did physical health problems limit your usual activities (such as walking or climbing stairs)?

Not at all	Very little	Somewhat	Quite a lot	Could not do physical activities
<input type="checkbox"/>				

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3. During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

None at all	A little bit	Some	Quite a lot	Could not do daily work
<input type="checkbox"/>				

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4. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very Severe
<input type="checkbox"/>					

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5. During the past 4 weeks, how much energy did you have?

Very much	Quite a lot	Some	A little	None
<input type="checkbox"/>				

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Please check that you have *answered each section*  
before moving onto the next page

## Part 4: continued

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6. During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family or friends?

Not at all	Very little	Somewhat	Quite a lot	Could not do social activities
<input type="checkbox"/>				

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7. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

Not at all	Slightly	Moderately	Quite a lot	Extremely
<input type="checkbox"/>				

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8. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

Not at all	Very little	Somewhat	Quite a lot	Could not do daily activities
<input type="checkbox"/>				

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*Now that you have completed the questionnaire please could you return it to us in the pre-paid envelope provided. Once again we would like to thank you for taking the time to help us with this research.*