*Progesterone Study:*

# Supplemental Progesterone Questionnaire: 35-37 Weeks

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TODAY'S DATE (D/M/Y): _______ / ______ / ______

PATIENT'S STUDY NUMBER: 14 – _____ – _________ PATIENT NAME: ___________________________

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| Patient's Perception of Risk of Adverse Birth Outcomes | | |
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| **Q1.** Do you think **pre-term delivery** (before 37 weeks/9 months) is a serious concern for the health/survival of an infant, in general? | ❑ 1 = Yes<br>❑ 2 = No<br>❑ 9 = Unsure | Why/Any Comments:<br>____________________________<br>____________________________ |
| **Q2.** Do you think **low-birth weight** (less than 2.5 kg) is a serious concern for the health/survival of an infant, in general? | ❑ 1 = Yes<br>❑ 2 = No<br>❑ 9 = Unsure | Why/Any Comments:<br>____________________________<br>____________________________ |
| **Q3.** For you personally, have you ever had concerns that you might have a baby that could be **born early** (before 37 weeks/9 months)? | ❑ 1 = Yes<br>❑ 2 = No<br>❑ 9 = Unsure | Why/Any Comments:<br>____________________________<br>____________________________ |
| **Q4.** For you personally, have you ever had concerns that you might have a baby that could be born **low birth weight** (less than 2.5 kg)? | ❑ 1 = Yes<br>❑ 2 = No<br>❑ 9 = Unsure | Why/Any Comments:<br>____________________________<br>____________________________ |

| Past Experience Taking Progesterone Medication | |
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| **Q5.** Has the patient ever taken progesterone medication before *any* reason such as birth control, preventing miscarriages, etc.? | ❑ 1 = Yes<br>❑ 2 = No<br>❑ 9 = Unsure |
| **Q5a.** If yes, for what reason was progesterone taken? | ❑ 1 = Birth Control ❑ 2= Prevent miscarriages<br>❑ 3 = Other (Specify): ______________________ |
| **IF YES TO THE ABOVE Q5., PLEASE ANSWER THE FOLLOWING QUESTIONS:** | |
| **Q5b.** By what route of administration did they previously take progesterone? (Check all that apply.) | ❑ 1 = Mouth-Tablet ❑ 3 = Vaginal-Tablet<br>❑ 2 = Intramuscular Injection ❑ 4 = Vaginal-Gel |
| **Q5c.** What was the frequency and duration for taking the progesterone medication in the past? | ________ times per _________ (day/week/month)<br>For ________ ___________ (days/weeks/months) |
| **Q5d.** Where did the patient take the progesterone medication? | ❑ 1 = At home (Self Administered)<br>❑ 2 = At a health clinic<br>❑ 3 = At a bigger medical centre or hospital<br>❑ 4 = Other (Specify): ____________________ |
| **Q5e.** Check **ALL** concerns or problems associated with taking the progesterone medication in the past. (Check all that apply.) | ❑ 1 = No concerns or problems<br>❑ 2 = Health Concerns (Specify): ____________<br>❑ 3 = Financial Concerns (Specify): ___________<br>❑ 4 = Inconvenience (Specify): ______________<br>❑ 5 = Other (Specify): ______________________ |

| Future Willingness to Take Progesterone Medication | |
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| **Q6.** **For a future pregnancy**, if there was a medicine you could take that would **prevent your baby from being born early**, and **ensure your baby is not low birth weight**, would you *consider* taking it? | ❑ 1 = Yes<br>❑ 2 = No<br>If NO, why not? ____________________________<br>___________________________________________ |

**IF NO TO THE ABOVE QUESTION, PLEASE PROCEED TO Q10** (THE LAST QUESTION).
**IF YES** (PATIENT WOULD CONSIDER TAKING MEDICATION DURING PREGNANCY), **PLEASE CONTINUE:**

**BY MOUTH – TABLET:**

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| **Q7.** If a doctor or a nurse prescribed/recommended taking the medicine by **MOUTH** (i.e. swallowing a tablet) to prevent preterm delivery or low birth weight, would the patient *consider* taking it? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________<br>___________________________________________ |
| **IF YES TO Q7,** (PATIENT WOULD CONSIDER TAKING MEDICINE BY MOUTH)**, PLEASE ANSWER 7a-e:** | |
| **Q7a.** Would the patient be willing to take the medicine by mouth **once each day**? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________ |
| **Q7b.** Would the patient be willing to take the medicine by mouth from Month 5 up to Month 9 of pregnancy (approximately half of the pregnancy)? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________ |
| **Q7c.** Where are **ALL** the places that the patient would be willing to take the medicine by mouth? (Check ALL that apply.) | ❑ 1 = At home (Self-Administered)<br>❑ 2 = At a health clinic<br>❑ 3 = At a bigger medical centre or hospital<br>❑ 4 = Other (Specify): ______________________ |
| **Q7d.** Does the patient have any HEALTH concerns related to taking this medicine by mouth? | ❑ 1 = Yes ❑ 2 = No<br>If YES, please describe:______________________<br>___________________________________________ |
| **Q7e.** Does the patient have any OTHER concerns (e.g. financial, inconvenience, etc.) associated with taking the medicine by mouth? | ❑ 1 = Yes ❑ 2 = No<br>If YES, please describe:______________________<br>___________________________________________ |

**BY INTRAMUSCULAR INJECTION:**

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| **Q8.** If a doctor or a nurse prescribed/recommended taking the medicine by **INTRAMUSCULAR INJECTION** to prevent preterm delivery or low birth weight, would the patient consider taking it? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________<br>___________________________________________ |
| **ONLY IF YES TO Q8,** (PATIENT WOULD CONSIDER TAKING MEDICINE BY INJECTION)**, PLEASE ANSWER 8a-e:** | |
| **Q8a.** Would the patient be willing to take the medicine by injection **once each week**? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________ |
| **Q8b.** Would the patient be willing to take the medicine by injection from Month 5 up to Month 9 of pregnancy (approximately half of the pregnancy)? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________ |

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| **Q8c.** Where are **ALL** the places that the patient would be willing to take the medicine by injection? (Check ALL that apply.) | ❑ 1 = At home (Self-Administered)<br>❑ 2 = At a health clinic<br>❑ 3 = At a bigger medical centre or hospital<br>❑ 4 = Other (Specify): ______________________ |
| **Q8d.** Does the patient have any HEALTH concerns related to taking this medicine by injection? | ❑ 1 = Yes ❑ 2 = No<br>If YES, please describe:______________________<br>__________________________________________ |
| **Q8e.** Does the patient have any OTHER concerns (e.g. financial, inconvenience, etc.) associated with taking the medicine by injection? | ❑ 1 = Yes ❑ 2 = No<br>If YES, please describe:______________________<br>__________________________________________ |

**VAGINALLY:**

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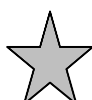
| **Q9.** If a doctor or a nurse prescribed/recommended taking the medicine **VAGINALLY BY TABLET OR GEL**, to prevent preterm delivery or low birth weight, would the patient *consider* taking it? | ❑ 1 = Yes to Both – Either Tablet or Gel<br>If Yes to Both, **which preferred**: __________<br>❑ 2 = Only Tablet, Not Gel<br>❑ 3 = Only Gel, Not Tablet<br>❑ 4 = No to Both Tablet and Gel<br>If NO to Vaginal Tablet and/or Gel, why not?<br>__________________________________________ |
| **ONLY IF YES TO Q9,** (PATIENT WOULD CONSIDER TAKING MEDICINE VAGINALLY, EITHER TABLET OR GEL), **PLEASE ANSWER 9a-e:** | |
| **Q9a.** Would the patient be willing to take the medication vaginally once each day? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________ |
| **Q9b.** Would the patient be willing to take the medication vaginally from Month 5 to Month 9 of pregnancy (approximately half of the pregnancy)? | ❑ 1 = Yes ❑ 2 = No<br>If NO, why not? ____________________________ |
| **Q9c.** Where are **ALL** the places that the patient would be willing to take the medicine vaginally? (Check ALL that apply.) | ❑ 1 = At home (Self-Administered)<br>❑ 2 = At a health clinic<br>❑ 3 = At a bigger medical centre or hospital<br>❑ 4 = Other (Specify): ______________________ |
| **Q9d.** Does the patient have any HEALTH concerns related to taking this medicine vaginally? | ❑ 1 = Yes ❑ 2 = No<br>If YES, please describe:______________________<br>__________________________________________ |
| **Q9e.** Does the patient have any OTHER concerns (e.g. financial, inconvenience, etc.) associated with taking the medicine vaginally? | ❑ 1 = Yes ❑ 2 = No<br>If YES, please describe:______________________<br>__________________________________________ |

*ANSWER THIS QUESTION FOR **ALL WOMEN** IN THE STUDY:*



**Q10.** Which form of supplemental progesterone would you be most likely to accept/prefer taking:

***IF YOU HAD TO CHOOSE JUST ONE:***

❑ 1 = Intramuscular Injection ❑ 2 = Vaginal-Tablet ❑ 3 = Vaginal-Gel