PARTICIPANT QUESTIONNAIRE – 3 MONTHS

Please complete this questionnaire 3 months after starting your study treatment.

Date of questionnaire completion (dd-mmm-yyyy): | | | | | | | | | | |

Thank you very much for taking the time to answer these questions for the VITA study.
Please be assured that all the data collected remains confidential. The VITA website is secure and only the study team have access to the information you are entering.

Please answer the questions as fully as possible. This should take approximately 10 minutes to complete.

If you have any problems please contact the trial team on vitahelp@nottingham.ac.uk

BACTERIAL VAGINOSIS (BV) SYMPTOMS – RESOLUTION

Had your original BV symptoms cleared by the end of week 2 (when you completed the week 2 questionnaire)? *By "original" we mean your BV symptoms at the beginning of the study (before treatment)*	Choose **one** of the following **4** options: **1.** ☐ My original BV symptoms cleared within the first two weeks (this could be with or without additional treatment, and even if they then came back). **2.** ☐ My original BV symptoms never cleared in the first two weeks but they did clear between 2 weeks and 3 months without additional treatment. **3.** ☐ My original BV symptoms never cleared in the first two weeks but they did clear between 2 weeks and 3 months with additional treatment. If you **ticked option 2 or 3** please confirm the date they cleared: |____|____|____|____|____|____|____|____| **4.** ☐ My original BV symptoms never cleared and are ongoing. ⓘ **If you chose option 4 please do NOT answer the section on "BV Symptoms – Recurrence" below but go straight to the section on "Additional Medications for your BV" and then complete the rest of the questionnaire.**

BACTERIAL VAGINOSIS (BV) SYMPTOMS – RECURRENCE

Have you experienced any **new** episodes of BV symptoms since your original symptoms cleared?	Yes* ☐ No☐
***If YES, please answer the following questions:**	
What was the date of your **first** new episode of BV?	☐☐ ☐☐☐ ☐☐☐☐
How many new episodes of BV type symptoms have you experienced?	☐☐
In total, approximately how many weeks have you had BV symptoms since your first episode of BV cleared?	☐ Less than 1 Week ☐ 1 to less than 2 Weeks ☐ 2 to 4 Weeks ☐ More than 4 Weeks
Were the recurrence(s) of your BV symptoms typical of your usual symptoms?	☐ Always ☐ Sometimes ☐ Seldom

ADDITIONAL MEDICATIONS FOR YOUR BV

In addition to your study treatment, have you used any additional medications for your BV **since completing your week 2 questionnaire?** (Either prescribed to you by a doctor or bought over the counter e.g. bought separately in a pharmacy or online)	☐Yes* ☐No
***If YES, please select the additional medication below:**	
	☐ **Metronidazole tablets** Were these prescribed? ☐Yes ☐No Number of courses taken? ☐☐
	☐ **Metronidazole vaginal gel** Was this prescribed? ☐Yes ☐No Number of courses taken? ☐☐
	☐ **Lactic acid vaginal gel** (e.g. Balance Activ®, Relactagel®, Canesbalance®) Was this prescribed? ☐Yes ☐No Number of courses taken? ☐☐
	☐ **Clindamycin cream** (e.g. Dalacin) Was this prescribed? ☐Yes ☐No Number of courses taken? ☐☐
	☐ **Other – please specify:** Was this prescribed? ☐Yes ☐No Number of courses taken? ☐☐

ANTIBIOTICS

Have you received any **antibiotics for any other condition/illness (not your BV)** since completing your week 2 questionnaire?	☐ Yes* ☐ No

***If YES, please select the antibiotic below:**

☐ **Amoxicillin**
Was this prescribed? ☐Yes ☐No

☐ **Flucloxacillin**
Was this prescribed? ☐Yes ☐No

☐ **Doxycycline**
Was this prescribed? ☐Yes ☐No

☐ **Other – Please specify:**

Was this prescribed? ☐Yes ☐No

THRUSH

Have you developed **vaginal thrush since completing your week 2 questionnaire?**	☐Yes* ☐No *If yes, please specify the date of onset (when the thrush started): __ __ __ __ __ __ __ __ How many episodes of vaginal thrush have you had? __ __

Are you pregnant, or have you been pregnant **since completing your week 2 questionnaire**?	☐ Yes – currently pregnant. Please specify approx due date: __ __ __ __ __ __ __ __ ☐ Yes – pregnant since completing the week 2 questionnaire but not currently ☐ No

Have you performed vaginal douching **since completing your week 2 questionnaire** (by vaginal douching, we mean washing inside your vagina)?	☐ Yes ☐ No

SEXUAL CONTACT

Have you had sex **since completing your week 2 questionnaire**?	☐ Yes* ☐ No
***If YES, please answer the questions below:**	
If yes, did you use condoms:	☐ Yes* ☐ No *If yes did you use condoms: ☐ Always (including oral sex) ☐ Not for oral sex but otherwise always ☐ Sometimes
Have you had any new sexual partners **since completing your week 2 questionnaire**?	☐ Yes ☐ No

Have you been diagnosed with HIV?	☐Yes ☐No

Have any of the following been diagnosed **since completing your 2 week questionnaire**? Please answer yes or no for each condition.		
Gonorrhoea	☐Yes* ☐No	*If yes Number of episodes: ___
Chlamydia	☐Yes* ☐No	*If yes Number of episodes: ___
Trichomonas	☐Yes* ☐No	*If yes Number of episodes: ___
Pelvic inflammatory disease	☐Yes* ☐No	*If yes Number of episodes: ___

USE OF HEALTH SERVICES FOR YOUR BV

Please record how many face-to-face or telephone consultations you have had with each of the following NHS services **since you completed your week 2 questionnaire**.
Only include those consultations that are related to your bacterial vaginosis or study treament

(please do not record your original visit where you were first prescribed your treatment)

NHS SERVICE	**Service used?**	***If YES, provide details:**	
		Face-to-face contact (please record the number of times)	Telephone contact (please record the number of calls)
GP appointment	☐Yes* ☐No	___	___
Nurse (GP Surgery) appointment	☐Yes* ☐No	___	___
Specialist sexual health clinic appointment (e.g. GUM clinic)	☐Yes* ☐No	___	___
NHS outpatient appointment (other than a specialist sexual health clinic/GUM clinic)	☐Yes* ☐No	___	___
NHS walk in centre	☐Yes* ☐No	___	___
NHS 111	☐Yes* ☐No		___
GP out of hours service	☐Yes* ☐No	___	___
Pharmacy	☐Yes* ☐No	___	___
A & E Department	☐Yes* ☐No	___	___
Other – Please specify:	☐Yes* ☐No	___	___

HOSPITAL ADMISSIONS – BV	
Since completing your week 2 questionnaire, have you been to hospital for an overnight stay because of problems related to your **bacterial vaginosis**?	☐ Yes* ☐ No
***If yes, please answer the questions below:**	
NHS or private hospital?	☐ NHS hospital ☐ Private hospital
Number of nights you stayed in hospital?	☐☐
Reason(s) for your stay(s) in hospital:	

SF-12™ QUESTIONNAIRE

Validated SF-12™ (4 week) Quality of Life questionnaire

– End of 3 month Questions –

THANK YOU

Thank you for completing this questionnaire. Your continued participation in the study is very much appreciated.

If your contact details have changed in the last 3 months please let us know by emailing: vitahelp@nottingham.ac.uk

We will send you another questionnaire in 3 months.

Other Comments
If you have any other comments about the study, please let us know below:
_____ _____ _____

Medical Attention
If you require any medical attention, please contact your GP/sexual health centre

Thank you for completing this questionnaire.