

United Kingdom Collaborative Trial of Ovarian Cancer Screening (UKCTOCS)

Please complete this form in **BLACK INK** and in **BLOCK CAPITALS**. It will help us check that you are eligible for the study as well as collect some data regarding your risk of developing ovarian cancer. If the personal or GP details are incorrect please insert the correct details into the "**Amended details**" box.

Your Personal Details

Amended details

Your GP Details

Dr

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NHS No.

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 D.o.B.

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 AP

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 ID

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Your Home Telephone No.

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Your Work Telephone No.

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ELIGIBILITY DETAILS (use black ink and BLOCK CAPITALS or place a cross "X" in the appropriate boxes)

1. When was your last period? (dd/mm/yyyy)

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2. Are you currently on Hormone Replacement Therapy (HRT)? Yes No
 If Yes then when did you start taking HRT? (dd/mm/yyyy)

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3. Have you had both your ovaries removed? Yes No

4. Have you ever had cancer diagnosed (except skin cancer)? Yes No
 If yes, what cancer was it? Ovary Breast Bowel Lung Other

When was it diagnosed? (dd/mm/yyyy)

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5. Have you had any treatment for any cancer (including surgery, chemotherapy, radiotherapy) in the last 12 months(not including tamoxifen)? Yes No

6. If any of the following relatives have had **OVARIAN CANCER** please write the number of affected relatives in the appropriate box. Please enter 0 for no affected relatives. (e.g. 0 Mother, 2 Sister, 0 Daughter).

Mother Daughter Sister Aunt GrandMother GrandDaughter

7. If any of the following relatives have had **BREAST CANCER** please write the number of affected relatives in the appropriate box. Please enter 0 for no affected relatives. (e.g. 0 Mother, 2 Sister, 1 Daughter).

Mother Daughter Sister Aunt GrandMother GrandDaughter

8. Are you currently taking part in any other ovarian cancer screening trial? Yes No

If yes what is your study reference number?

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ADDITIONAL INFORMATION

ID

9. Your height (cm) Your weight (kg)

Or (in) Or (lb)

10. Country of birth (please place an "X" as appropriate)

England Northern Ireland Scotland Irish Republic Wales Elsewhere

11. Ethnic group, please place an "X" in the appropriate box. (If you are descended from more than one ethnic or racial group, please select the group you consider you belong to or choose "Any other ethnic origin")

White Indian Pakistani Chinese Bangladeshi

Black-African Black-Caribbean Black-other Any other ethnic origin

12. At what age did you first have your period?

13. How many pregnancies have you had which ended before they reached 6 months (including miscarriages, ectopic pregnancies)?

14. How many pregnancies have you had which lasted beyond 6 months (including all deliveries - both term and preterm)?

15. Have you ever taken the oral contraceptive pill? Yes No

If yes, how many years in total did you take the pill? Years

16. Have you ever had a hysterectomy (removal of the womb)? Yes No

17. Have you had a sterilisation operation (To block your tubes)? Yes No

18. Have you ever had any treatment for infertility? Yes No