

## OVARIAN CANCER DETECTION PROGRAM

### SCHEDULE OF TESTS AND EXAMINATIONS

Tests and Examinations	Initial visit	3 Mos	6 Mos	9 Mos	12 Mos	18 Mos	24 Mos
History and Physical Exam	X		X		X		X
Serum Markers	X		X		X	X	X
Stool for Occult Blood	X		X		X		X
Pap Smear	X				X		X
Endometrial Biopsy	optional				optional		Optional
Mammogram	X				X		X
Ultrasound Exam		X		X		X	

These tests or recent results can be provided by your own physician.

#### **Three and Nine Months From Your Initial Visit:**

- Schedule a Doppler Ultrasound Examination.
- This test must be done between days 2-7 of your period.
- On the first day of your period, please call Lucille at [688-2433](tel:688-2433) to schedule these appointments.

#### **Six and Twelve Months from Your Initial Visit:**

- Return to GYN-ONCOLOGY in YPB-3 for your follow up examinations.
- Please call Diane Chandler at [785-4176](tel:785-4176) to schedule these appointments.

#### **After Twelve Months From the Initial Visit:**

- The schedule changes.
- You will be seen every six months for urine and blood work tests.
- At each six months follow up, your examinations will alternate between a physical and ultrasound examination. Call the appropriate phone numbers listed above to schedule these appointments.

## **YALE GYNECOLOGIC ONCOLOGY EARLY DETECTION PROGRAM**

### **SECTION A (SOCIAL BACKGROUND & OCCUPATIONAL EXPOSURES)**

Patient's Name: \_\_\_\_\_  
(last) (first) (maiden)

Address: \_\_\_\_\_

---

(city) (state) (zip)  
Telephone Nos.: (\_\_\_\_) \_\_\_\_\_ (home) (\_\_\_\_) \_\_\_\_\_ (work)

Cities/States lived in during the past 30 years: \_\_\_\_\_

---

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace: \_\_\_\_\_  
(month) (day) (year) (city) (state)

Ethnic Background: \_\_\_White \_\_\_Black \_\_\_Hispanic \_\_\_Am. Indian \_\_\_ Divorced  
Spouse's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Patient's Occupation for the past 30 years: \_\_\_\_\_

---

Environmental exposure:

Check one: (U) Usually (O) Occasionally (N) Never  
(indicate: age job started/stopped)

Asbestos \_\_\_ (\_\_\_ to \_\_\_) Chemical/Acids/Solvents \_\_\_ (\_\_\_ to \_\_\_)

Gases/Fumes \_\_\_ (\_\_\_ to \_\_\_) Coal tar/pitch/asphalt \_\_\_ (\_\_\_ to \_\_\_)

Gasoline/oil \_\_\_ (\_\_\_ to \_\_\_) Pesticides/herbicides \_\_\_ (\_\_\_ to \_\_\_)

Dyes \_\_\_ (\_\_\_ to \_\_\_) Formaldehyde (foam, other) \_\_\_ (\_\_\_ to \_\_\_)

Textiles \_\_\_ (\_\_\_ to \_\_\_) Coal/stone/wood dust \_\_\_ (\_\_\_ to \_\_\_)

Smoke \_\_\_ (\_\_\_ to \_\_\_) X-rays/radioactivity \_\_\_ (\_\_\_ to \_\_\_)

Physician's (G.P.) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

**SECTION B (PAST MEDICAL HISTORY):**

(If yes, indicate dates, where treated and by whom beside each section)

Have You Had:	(check one)	YES	NO
Mumps.....		_____	_____
German measles .....		_____	_____
Bleeding tendencies .....		_____	_____
Migraine headaches .....		_____	_____
Thyroid disease .....		_____	_____
Pneumonia .....		_____	_____
Tuberculosis .....		_____	_____
High blood pressure .....		_____	_____
Rheumatic fever .....		_____	_____
Rheumatic heart disease .....		_____	_____
Anemia .....		_____	_____
Congenital heart disease .....		_____	_____
Phlebitis .....		_____	_____
Diabetes .....		_____	_____
Hepatitis (yellow jaundice) .....		_____	_____
Chronic kidney disease .....		_____	_____
Venereal disease .....		_____	_____
Psychiatric illness .....		_____	_____
Epilepsy .....		_____	_____
Radiation therapy .....		_____	_____
Genetic Abnormalities .....		_____	_____
Allergies .....		_____	_____
Other .....		_____	_____
Blood Type .....A_____ B_____ AB_____ O _____			
Rh Factor.... Rh + _____ Rh - _____			

Describe previous Yes answers:

**SURGICAL: List any surgical procedures you have and in your lifetime.**



Age at Menarche: \_\_\_\_\_ Periods: \_\_\_\_\_Regular \_\_\_\_\_Irregular (specify \_\_\_\_\_  
\_\_\_\_\_)

Menopause: \_\_\_No \_\_\_Yes (age \_\_\_\_\_ Spontaneous \_\_\_\_\_Surgical \_\_\_\_\_Pharmacol)

Birth Control Methods: \_\_\_\_\_Never \_\_\_\_\_Yes

If yes complete for each method:

			Age started	# Years Used
Oral Contraceptives:	_____ Never	_____ Yes	_____	_____
Diaphragm:	_____ Never	_____ Yes	_____	_____
Condom:	_____ Never	_____ Yes	_____	_____
I U D:	_____ Never	_____ Yes	_____	_____
Rhythm:	_____ Never	_____ Yes	_____	_____
Other	_____ Never	_____ Yes	_____	_____

If other please specify: \_\_\_\_\_

Previous Use of Other Estrogen: \_\_\_\_\_ Never \_\_\_\_\_ Yes (specify \_\_\_\_\_  
\_\_\_\_\_)

Sexual Intercourse: \_\_\_\_\_ Never \_\_\_\_\_ Yes (age at coitarche \_\_\_\_\_)

# Pregnancies: \_\_\_\_\_ # Live Births: \_\_\_\_\_ # Still Births: \_\_\_\_\_

# Miscarriages and Abortions: \_\_\_\_\_

No. Children Breast Fed: \_\_\_\_\_

If one or more add total number of months breast feeding: \_\_\_\_\_

Use of Talcum Powder (genital area): \_\_\_\_\_ Never \_\_\_\_\_ Yes

i. on a sanitary napkin: \_\_\_\_\_ regularly \_\_\_\_\_ occasionally (X years \_\_\_\_\_)

ii. directly on  
genital region or thighs: \_\_\_\_\_ regularly \_\_\_\_\_ occasionally (X years \_\_\_\_\_)

Tobacco: \_\_\_\_\_ Never \_\_\_\_\_ Yes (age started \_\_\_\_\_ mean no. cigarettes/day \_\_\_\_\_  
(age stopped \_\_\_\_\_)

Alcohol: \_\_\_\_\_ Never \_\_\_\_\_ Yes (age started \_\_\_\_\_ age stopped \_\_\_\_\_)

Other: specify \_\_\_\_\_

---

**SECTION D (Family Member's History Of Cancer)**

This section is to be possibly completed for each case of ovarian, breast, endometrial, or colon or rectal cancer in family members. Please write "unknown" everywhere it is not possible to give detailed information.)

Patient's Name: \_\_\_\_\_  
(last) (first) (maiden)

Relationship to Patient: \_\_\_\_\_

Diagnosis of Ovarian Cancer (histologic confirmation): \_\_\_\_/\_\_\_\_/\_\_\_\_  
(month) (day) (year)

Age at Diagnosis of Ovarian Cancer: \_\_\_\_\_

Initial Stage (FIGO): \_\_\_\_\_ Bilateral: \_\_\_\_ No \_\_\_\_ Yes

Histology: \_\_\_\_\_ Grade of Tumor Differentiation (FIGO) \_\_\_\_\_

Hospital from where ovarian cancer slides may be obtained:

Treatment: \_\_\_\_\_

Disease Status and Survival (Months): \_\_\_\_\_

---

**HISTORY OF BREAST CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis

\_\_\_\_\_

Stage (TNM): \_\_\_\_\_ Histology: \_\_\_\_\_

Treatment: \_\_\_\_\_

Disease Status: \_\_\_\_\_

**HISTORY OF ENDOMETRIAL CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis

\_\_\_\_\_

Stage (FIGO): \_\_\_\_\_ Grade (FIGO): \_\_\_\_\_

Histology: \_\_\_\_\_ Depth of Myometrial Invasion: \_\_\_\_\_

Treatment: \_\_\_\_\_

**HISTORY OF COLON OR RECTAL CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis \_\_\_\_

Stage (TNM): \_\_\_\_\_ Histology: \_\_\_\_\_

Treatment: \_\_\_\_\_

Disease Status: \_\_\_\_\_

**HISTORY OF OTHER CANCER/S** \_\_\_\_ No \_\_\_\_ Yes (specify \_\_\_\_\_)

\_\_\_\_\_

**SECTION D (Family Member's History Of Cancer)**

This section is to be possibly completed for each case of ovarian, breast, endometrial, or colon or rectal cancer in family members. Please write "unknown" everywhere it is not possible to give detailed information.)

Patient's Name: \_\_\_\_\_  
(last) (first) (maiden)

Relationship to Patient: \_\_\_\_\_

Diagnosis of Ovarian Cancer (histologic confirmation): \_\_\_\_/\_\_\_\_/\_\_\_\_  
(month) (day) (year)

Age at Diagnosis of Ovarian Cancer: \_\_\_\_\_

Initial Stage (FIGO): \_\_\_\_\_ Bilateral: \_\_\_\_ No \_\_\_\_ Yes

Histology: \_\_\_\_\_ Grade of Tumor Differentiation (FIGO) \_\_\_\_\_

Hospital from where ovarian cancer slides may be obtained:

Treatment: \_\_\_\_\_

Disease Status and Survival (Months): \_\_\_\_\_

---

**HISTORY OF BREAST CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis

\_\_\_\_\_

Stage (TNM): \_\_\_\_\_ Histology: \_\_\_\_\_

Treatment: \_\_\_\_\_

Disease Status: \_\_\_\_\_

**HISTORY OF ENDOMETRIAL CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis

\_\_\_\_\_

Stage (FIGO): \_\_\_\_\_ Grade (FIGO): \_\_\_\_\_

Histology: \_\_\_\_\_ Depth of Myometrial Invasion: \_\_\_\_\_

Treatment: \_\_\_\_\_

**HISTORY OF COLON OR RECTAL CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis \_\_\_\_

Stage (TNM): \_\_\_\_\_ Histology: \_\_\_\_\_

Treatment: \_\_\_\_\_

Disease Status: \_\_\_\_\_

**HISTORY OF OTHER CANCER/S** \_\_\_\_ No \_\_\_\_ Yes (specify \_\_\_\_\_

\_\_\_\_\_

**SECTION D (Family Member's History Of Cancer)**

This section is to be possibly completed for each case of ovarian, breast, endometrial, or colon or rectal cancer in family members. Please write "unknown" everywhere it is not possible to give detailed information.)

Patient's Name: \_\_\_\_\_  
(last) (first) (maiden)

Relationship to Patient: \_\_\_\_\_

Diagnosis of Ovarian Cancer (histologic confirmation): \_\_\_\_/\_\_\_\_/\_\_\_\_  
(month) (day) (year)

Age at Diagnosis of Ovarian Cancer: \_\_\_\_\_

Initial Stage (FIGO): \_\_\_\_\_ Bilateral: \_\_\_\_ No \_\_\_\_ Yes

Histology: \_\_\_\_\_ Grade of Tumor Differentiation (FIGO) \_\_\_\_\_

Hospital from where ovarian cancer slides may be obtained:

Treatment: \_\_\_\_\_

Disease Status and Survival (Months): \_\_\_\_\_

---

**HISTORY OF BREAST CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis \_\_\_\_\_

Stage (TNM): \_\_\_\_\_ Histology: \_\_\_\_\_

Treatment: \_\_\_\_\_

Disease Status: \_\_\_\_\_

**HISTORY OF ENDOMETRIAL CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis \_\_\_\_\_

Stage (FIGO): \_\_\_\_\_ Grade (FIGO): \_\_\_\_\_

Histology: \_\_\_\_\_ Depth of Myometrial Invasion: \_\_\_\_\_

Treatment: \_\_\_\_\_

**HISTORY OF COLON OR RECTAL CANCER:** \_\_\_\_ No \_\_\_\_ Yes Age at Diagnosis \_\_\_\_\_

Stage (TNM): \_\_\_\_\_ Histology: \_\_\_\_\_

Treatment: \_\_\_\_\_

Disease Status: \_\_\_\_\_

**HISTORY OF OTHER CANCER/S** \_\_\_\_ No \_\_\_\_ Yes (specify \_\_\_\_\_)

---

**SECTION E. (Information concerning immediate family)**

(If additional space is required, attach another page)

Name & Address	Birth Date	Death Date	Death Cause	Cancer? Site/s Hospital	Age At Diagnosis	Smoke	No of Children	Any With Cancer? *
Patient's Mother							////// ////// //////	////// ////// //////
Patient's Father							////// ////// //////	////// ////// //////
Patient's children								
1.								
2.								
3.								
4.								
5.								
6.								
Patient's brothers And sisters								
1.								
2.								
3.								
4.								
5.								
6.								

(\*) Specify name, site of cancer/s, and hospital where treated.

**SECTION E. (Information concerning immediate family)**

(If additional space is required, attach another page)

Name & Address	Birth Date	Death Date	Death Cause	Cancer? Site/s Hospital	Age At Diagnosis	Smoke	No of Children	Any With Cancer? *
Patient's Mother							////// ////// //////	////// ////// //////
Patient's Father							////// ////// //////	////// ////// //////
Patient's children								
1.								
2.								
3.								
4.								
5.								
6.								
Patient's brothers And sisters								
1.								
2.								
3.								
4.								
5.								
6.								

(\*) Specify name, site of cancer/s, and hospital where treated.

**SECTION E. (Information concerning immediate family) continued**

(If additional space is required, attach another page)

Name & Address	Birth Date	Death Date	Death Cause	Cancer? Site/s Hospital	Age At Diagnosis	Smoke	No of Children	Any With Cancer? *
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Maternal aunts And uncles 1.								
2.								
3.								
4.								
Paternal aunts And uncles 1.								
2.								
3.								

(\*) Specify name, site of cancer/s, and hospital where treated.



**AUTHORIZATION FORM**

**I hereby authorize the Yale Ovarian Cancer Screening Program to contact family members and to obtain my medical records from hospital(s), in the furtherance of the research studies they are conducting.**

**This signed authorization form may also be used in obtaining the records of close relatives who are deceased and whose medical records I authorized by law to release.**

**This is my personal contribution, freely given for the furthering of biomedical research.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_