UKCTOCS

United Kingdom Collaborative Trial of Ovarian Cancer Screening

Second Follow-up Health Questionnaire

Thank you for taking part in UKCTOCS. Please answer every question as fully as you can.

If you are not sure of the exact dates/ details, an approximate answer is better than none.

Please use a **BLACK** pen and where appropriate place a cross [X] inside the box for your answer. Any information that you provide will be treated in the strictest of confidence and will only be used for research purposes. We may contact you if anything is unclear.

We appreciate your time and effort in completing this questionnaire. If possible, please return the questionnaire within 21 days of receipt.

SECTION I: YOUR CONTACT DETAILS

1. **Do you have an email address that we can use to contact you in the future?** Yes ☐ No ☐
   If yes, please provide below. Email address:

2. **If you have received this questionnaire as redirected mail, please enter your current contact details below so that we can update our records:**

   Address: ....

   Town: .... County: .... Postcode: ☐☐☐☐ ☐☐☐

If your contact details change in the future, please do provide us with your new postal or email address. We will email you the results of the trial when analysis is completed in 2015 if you have an email address.

SECTION II: GENERAL INFORMATION THAT WE DID NOT ASK PREVIOUSLY

1. **Marital Status** (please tick only one box)

   (a) Current:

   ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

   (b) Before trial started in 2000

   ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

2. **What was your primary occupation?** (Please enter the role in which you have been engaged the longest)

   ....

3. **Please measure and enter the following measurements:**

(a) Your height: ☐ feet ☐☐ inches (b) Your weight: ☐☐ stones ☐☐ lbs

(c) Your waist: ☐☐ inches (d) Your hips: ☐☐ inches

SECTION III: GYNAECOLOGICAL MEDICAL HISTORY – SURGICAL AND INVESTIGATIVE PROCEDURES

Have you had any of the following procedures since joining UKCTOCS?
If yes, please enter the details below. Multiple boxes can be filled; please fill even if you had the procedures as part of the trial.

1. **Operation to look at/remove your ovaries/fallopian tubes** Yes ☐ No ☐
2. **Operation to look into your womb (hysteroscopy), endometrial biopsy (removal of some tissue from your womb) or D & C (scrape of your womb)** Yes ☐ No ☐
3. **Operation to remove your womb (hysterectomy)** Yes ☐ No ☐
4. **Operation to remove part or whole of your breast(s) (e.g. lumpectomy/ wide local excision/mastectomy)** Yes ☐ No ☐

Any other gynaecological surgery Yes ☐ No ☐

5. **If you have ticked 'Yes' to any of the above, please provide details**

a) Type of operation:

Date of surgery: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

Hospital Name:

Hospital Number: Name of Consultant:

b) Type of operation:

Date of surgery: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

Hospital Name:

Hospital Number: Name of Consultant:

SECTION IV: YOUR MEDICAL HISTORY

1. **Since joining UKCTOCS have you been diagnosed with any cancer?** *(multiple boxes can be filled)*

☐ **I have not been diagnosed with any cancers**

☐ Ovarian cancer ☐ Bowel/colorectal cancer ☐ Lymphoma
☐ Breast cancer ☐ Gastric/stomach cancer ☐ Leukaemia
☐ Cervical cancer ☐ Pancreatic cancer ☐ BCC/rodent/skin cancer
☐ Endometrial/womb cancer ☐ Kidney cancer ☐ Melanoma
☐ Vulval/vaginal cancer ☐ Bladder cancer ☐ Other cancer (please specify below)

2. **If you have ticked any of the above cancers, please provide details of the main treating hospital where you had your surgery or chemotherapy:**

a) Type of cancer: Date of diagnosis: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

Hospital Name:

Hospital Number: Name of Consultant:

b) Type of cancer: Date of diagnosis: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

Hospital Name:

Hospital Number: Name of Consultant:

3. **Do you have/are being treated for any of the following conditions?** *(multiple boxes can be filled)*

☐ **I do not have any of these conditions**

☐ High blood pressure
☐ Heart disease (e.g. heart attack, angina)
☐ High blood cholesterol
☐ Stroke
☐ Diabetes
☐ Rheumatoid arthritis
☐ Osteoarthritis
☐ Osteoporosis
☐ Thyroid disease
☐ Kidney disease
☐ Inflammatory bowel disease
☐ Liver disease
☐ Chronic Obstructive Pulmonary Disease

4. **If you have ticked any of the above conditions, please provide details of the main treating hospital:**

a) Condition: Date of diagnosis: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

Hospital Name:

Hospital Number: Name of Consultant:

b) Condition: Date of diagnosis: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

Hospital Name:

Hospital Number: Name of Consultant:

5. **Have you ever taken any of the following medications?**

Tamoxifen	Yes ☐ No ☐	Start date ☐☐ / ☐☐ / ☐☐	Stop date ☐☐ / ☐☐ / ☐☐
Statins	Yes ☐ No ☐	Start date ☐☐ / ☐☐ / ☐☐	Stop date ☐☐ / ☐☐ / ☐☐
Low-dose aspirin	Yes ☐ No ☐	Start date ☐☐ / ☐☐ / ☐☐	Stop date ☐☐ / ☐☐ / ☐☐

SECTION V: ADDITIONAL OVARIAN CANCER SCREENING

1. **Have you had any screening for ovarian cancer OUTSIDE UKCTOCS?** Yes ☐ No ☐

2. **If yes, when was it done and where was this performed?** Date: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

☐ NHS Hospital Hospital name:

☐ GP surgery Practice name:

☐ UKCTOCS Trial Centre Name of Centre:

☐ Private Clinic Details of private clinic:

3. **Why was it done?**

☐ Symptoms ☐ Screening ☐ Your request ☐ Other reason (please specify)

4. **If yes, was it abnormal?** Yes ☐ No ☐
   Did it result in additional tests? Yes ☐ No ☐
   Did it result in surgery? Yes ☐ No ☐
   Did it lead to a cancer diagnosis? Yes ☐ No ☐

5. **Since joining UKCTOCS have you had an ultrasound scan?** Yes ☐ No ☐

6. **If yes, when was it done and where was this performed?** Date: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

   ☐ NHS Hospital Hospital name:

   ☐ GP surgery Practice name:

   ☐ UKCTOCS Trial Centre Name of Centre:

   ☐ Private Clinic Details of private clinic:

7. **Why was it done?**

   ☐ Symptoms ☐ Screening ☐ Your request ☐ Other reason (please specify)

8. **If yes, was it abnormal?** Yes ☐ No ☐
   Did it result in additional tests? Yes ☐ No ☐
   Did it result in surgery? Yes ☐ No ☐
   Did it lead to a cancer diagnosis? Yes ☐ No ☐

SECTION VI: YOUR FAMILY HISTORY OF CANCER

1. **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 ☐ Paternal Aunt ☐ Paternal Grandmother
   ☐ Sister ☐ Granddaughter ☐ Maternal Aunt ☐ Maternal Grandmother

2. **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 ☐ Paternal Aunt ☐ Paternal Grandmother
   ☐ Sister ☐ Granddaughter ☐ Maternal Aunt ☐ Maternal Grandmother

3. **If any of the following relatives have had ENDOMETRIAL 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 ☐ Paternal Aunt ☐ Paternal Grandmother
   ☐ Sister ☐ Granddaughter ☐ Maternal Aunt ☐ Maternal Grandmother

Please enter the date you completed this questionnaire: ☐☐ / ☐☐ / ☐☐ (dd/mm/yy)

On completion, please check to make sure you have answered **all** the questions. Please return the questionnaire to us in the **FREEPOST** envelope provided.

Thank you for taking the time to complete this questionnaire. The information that you supply is of great importance to the success of the trial.