



The initial efforts of The Maureen Fund are to identify those women who may be at risk for developing ovarian cancer by asking them to fill out a simple questionnaire. The questionnaire provides a list risk factors and symptoms that may be associated with ovarian cancer. The majority of women with the risk factors or symptoms on the questionnaire do not have cancer, however, early intervention for those at high risk can save lives.

Please print out the attached questionnaire.

Mail completed form back to:

The Maureen Fund For Ovarian Cancer

The Cancer Center @ HUMC

30 Prospect Avenue

Hackensack, New Jersey 07601

Once The Maureen Fund receives the completed questionnaire you will be contacted by one of our healthcare professionals to verify risk factors and to set up an appointment for a consultation. When appropriate, screening ultrasonography, and a blood test for the CA125 tumor marker will be made available.

If you have any further questions or need assistance in completing the attached form, please call:

The Maureen Fund @ 201-996-4287.

Personal OB/GYN History:

Age at first menstruation _____ Number of children _____
Number of children born after age 30 _____ Age at menopause _____ Not Applicable

Are you/Have you taken hormone replacements? Yes No
If yes, for how many years? _____

Are you/Have you taken oral contraceptives? Yes No
If yes, for how many years? _____

Are you/Have you taken fertility drugs? Yes No
If yes, for how long? _____

Are you experiencing any abnormal vaginal bleeding,
including post-menopausal bleeding? Yes No

Are you experiencing any pelvic pain or discomfort? Yes No

Are you experiencing any low backache or cramps? Yes No

Are you experiencing any pain during intercourse? Yes No

General Health Concerns:

Are you experiencing a sense of fullness,
bloating or pressure in the pelvis or abdomen? Yes No

Are you experiencing any persistent changes in bowel
or bladder pattern such as constipation, diarrhea, or incontinence? Yes No

Are you experiencing urinary urgency without infection? Yes No

Are you experiencing a sudden loss of urine when you cough? Yes No

Are you experiencing any persistent nausea, indigestion or gas? Yes No

Are you experiencing any unexplained weight loss or gain? Yes No

Are you experiencing ongoing unusual fatigue? Yes No

Do you frequently use talcum powder for personal hygiene? Yes No

Signature _____ **Date** _____

For HUMC use only:

Date received: _____ **Control number:** _____ **Follow up completed:** _____

Additional Information: _____

Signature: _____ **Date:** _____