Ovarian Cancer Screening

Name____ **Date**_____________

Symptom	Severity (0=none, 1=minimal, 5=severe)						Frequency (Episodes/month)	Duration (months)
Pain								
☐ Pelvic	0	1	2	3	4	5	________	________
☐ Abdominal	0	1	2	3	4	5	________	________
☐ Back	0	1	2	3	4	5	________	________
Eating								
☐ Indigestion	0	1	2	3	4	5	________	________
☐ Unable to eat normally	0	1	2	3	4	5	________	________
☐ Nausea or vomiting	0	1	2	3	4	5	________	________
☐ Weight loss	0	1	2	3	4	5	________	________
Abdomen								
☐ Abdominal bloating	0	1	2	3	4	5	________	________
☐ Increased abdominal size	0	1	2	3	4	5	________	________
☐ Able to feel abdominal mass	0	1	2	3	4	5	________	________
Bladder								
☐ Urinary urgency	0	1	2	3	4	5	________	________
☐ Frequent urination	0	1	2	3	4	5	________	________
Bowels								
☐ Constipation	0	1	2	3	4	5	________	________
☐ Diarrhea	0	1	2	3	4	5	________	________
Menses								
☐ Menstrual irregularities	0	1	2	3	4	5	________	________
☐ Bleeding after menopause	0	1	2	3	4	5	________	________
Intercourse								
☐ Pain during intercourse	0	1	2	3	4	5	________	________
☐ Bleeding with intercourse	0	1	2	3	4	5	________	________
Miscellaneous								
☐ Fatigue	0	1	2	3	4	5	________	________
☐ Leg swelling	0	1	2	3	4	5	________	________
☐ No symptoms	0	1	2	3	4	5	________	________