DESERT · MEDICAL · IMAGING

Prostate Questionnaire

Patient Name:_____Date: _____

Height: _____ Weight:_____Date of Birth: _____

Referring Physician:_____

1. What is your serum PSA? Date(s) _____
2. What are your urine PCA3 results? Date(s) _____
3. Have you had a Transrectal Ultrasound Guided Biopsy (TRUS)? If so, when? _____

   What were the biopsy results? _____
4. Do you have a history of prostatitis? If so, have you been treated with antibiotics? _____
5. If you have prostate cancer:

   a. What is your Gleason score?_____

   b. Have you had a prostate MRI? If so, when? _____

   c. Have you had staging imaging including CT Abdomen/Pelvis or nuclear medicine bone scan?_____

   _____

   d. Has your prostate cancer been treated?

      1. Surgery? Yes ☐ No ☐ _____
      2. Radiation therapy? Yes ☐ No ☐ Type? _____
      3. Hormone therapy? Yes ☐ No ☐ _____
      4. Other _____
6. Do you take any medications for your prostate? If so what? _____

   _____

   _____
7. Are you being treated with Testosterone? Yes ☐ No ☐
8. Have you had surgery for BPH (Benign Prostatic Hyperplasia)?

   a. TURP?_____Date(s)_____

   b. Laser?_____Date(s)_____
9. Do you have a family history of prostate cancer? If so, who? _____

Patient Signature:_____Date: _____