Elevation Medical
IMAGING

Prostate Health History Questionaire

Physician Name: _____

Patient Name: _____ Date of Service: ____/____/____

DOB: ____/____/_____ Age: _____ Height: _____ Weight: _____

CHIEF COMPLAINT (What is the main reason for your visit today?) _____

_____

_____

Date of onset: _____ List location (left or right): _____

Any Test? What type? _____

☐Yes ☐No **Previous prostate MRI at ProScan?**
Date: _____

☐Yes ☐No **Been diagnosed with prostate cancer?**

☐Yes ☐No **Do you know your Gleason score?** _____

☐Yes ☐No **Do you know your PSA level?** _____ ng/mL

☐Yes ☐No **Had a prostate biopsy?**
Date: _____

☐Yes ☐No **Abnormal rectal exam?**

☐Yes ☐No **Blood in urine?**

☐Yes ☐No **Burning with urination?**

☐Yes ☐No **Leaking of urine?**
☐With exercise ☐With cough

☐Yes ☐No **Clots in urine?**

☐Yes ☐No **Pain with intercourse?**

☐Yes ☐No **Problems with erections?**

☐Yes ☐No **Urinating at night?** _____ times a night

☐Yes ☐No **Diabetic?**

☐Yes ☐No **Family history of prostate cancer?**
☐Grandfather ☐Father ☐Brother
☐Other: _____

☐Yes ☐No **Medications?**
If yes, please list: _____
_____
_____
_____
_____

Tech Notes:

913 E. Boxelder Rd. Gillette, WY 82718 • P:307.682.1779 • F. 307.682.1745