Prostate MRI Questionnaire

University 3T MRI Centre

Patient Name:_____ _____ _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____
(MM/DD/YYYY)

AHC #:_____

Patient Height _____ in/cm Patient Weight_____ lbs/kgs

Is there a history of a prostate biopsy? No ☐ Yes ☐
If yes, please provide dates and results:

Dates and results for ALL PSAs done:

Date:_____ Result:_____

Date:_____ Result:_____

Date:_____ Result:_____

Is there a history of treatement for prostate disease in the past or currently receiving treatment?
No ☐ Yes ☐
If yes, please describe:

Is there a history of any other pelvic disease? No ☐ Yes ☐
If yes, please describe:

Is there a history of any pelvic surgeries / treatments? No ☐ Yes ☐
If yes, please describe:

Questionnaire completed by:	
Name (please print):	Signature: Date (MM-DD-YYYY)