Lexington Diagnostic Center Questionnaire

MRI Prostate

Today's Date:_____

Account #: _____

Name_____ Age _____

When are you seeing your doctor again?_____

What are your symptoms?_____

How long have you had symptoms?_____

Have you had surgery to area we are scanning? YES NO

What type of surgery?_____

Date of surgery?_____

Have you had x-rays of the area we are scanning? YES NO Date of X-rays?_____

Have you had previous CT(s)? YES NO Date of CT(s)_____

Have you had previous MRI(s)? YES NO Date of MRI(s)_____

Are you claustrophobic? YES NO

Have you been diagnosed with prostate cancer? YES NO

Have you been diagnosed with other cancers? YES NO

If yes, what kind and to what body part?_____

Have you ever had a prostate biopsy? YES NO

If yes, please list when, where, and the results:_____

_____

_____

Have you had therapy or treatment for your prostate in the past? YES NO

If yes, what type?_____Treating Doctor:_____

Are you currently on therapy or being treated for prostate cancer? YES NO

If yes, what type?_____Treating Doctor:_____

What is your PSA level?_____

Are you scheduled for prostate surgery? YES NO When? _____

Receptionist initials _____ Form filled out by _____