HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PROSTATE ULTRASOUND QUESTIONNAIRE

The following information is extremely important in providing you with the best possible examination. Please fill out this form as completely as possible.

1. Are you taking any antibiotics for this procedure? ☐ No ☐ Yes, name of drug: _____
2. Do you have heart disease or heart valve disease? ☐ No ☐ Yes, please describe: _____
3. What medications do you routinely take? Please fill out Medication Reconciliation form.
4. Why did your physician recommend this exam? _____
5. What is your PSA (Prostate Specific Antigen) level? _____
6. Have you ever had an ultrasound examination of the prostate? ☐ No ☐ Yes, where and when:

   _____
7. When was your most recent digital (finger) rectal examination? _____ Did your physician feel any abnormality? _____
8. Is there a history of prostate cancer in your family? ☐ No ☐ Yes, please describe: _____

   _____
9. Have you ever had prostate surgery? ☐ No ☐ Yes

   Have you had a Trans Urethral resection of the Prostate (TURP, a scraping of the prostatic urethra)? ☐ No ☐ Yes

   If yes, when? _____
10. Have you had a biopsy of the prostate taken? ☐ No ☐ Yes, when? _____
11. Have you been diagnosed as having prostate cancer? ☐ No ☐ Yes

    If yes, have you had any treatment for that cancer? ☐ No ☐ Yes, please list treatment:

    Treatment: _____ Date: _____

    Treatment: _____ Date: _____

Patient Signature: _____ _____ Date/Time: _____

Reviewed by: _____ _____ Date/Time: _____

PATIENT HEALTH HISTORY
Department of Radiology

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