



PROSTATE / MALE PELVIS QUESTIONNAIRE

RADIOLOGY

NAME: _____ AGE: _____

DIAGNOSIS (Why are you having this study?): _____

PLEASE CHECK EACH BOX THAT APPLIES TO YOU (AND ANSWER QUESTIONS):

- Pelvic pain
- Pain on urination
- Difficulty urinating
- Other symptoms? Please describe. _____
- Blood in urine
- Sexual dysfunction

PROSTATE

What is your PSA level? _____

Have you had a prostate biopsy? Yes No

 If yes, when? _____

 Results? _____

If you have prostate cancer, have you received any treatment? Yes No

 If yes, what type?

 Surgery Yes No

 Radiation Yes No

 Radiation seed implants Yes No

 Have you had prostatitis? Yes No

SCROTUM / TESTES

Do you have a scrotal mass? Yes No

 If yes, which side? Right Left

Do you have scrotal pain? Yes No

 If yes, which side? Right Left

Have you had recent trauma? Yes No

 If yes, which side? Right Left

Have you had infection or inflammation in your scrotum? Yes No

 If yes, which side? Right Left

Any other relevant symptoms? Please describe: _____

PRIOR STUDIES AND INTERVENTION:

- Prior MRI (when?) _____ (where?) _____
- Ultrasound (when?) _____ (where?) _____
- CT (CAT) scan (when?) _____ (where?) _____
- Bone scan (when?) _____ (results?) _____
- Other studies and interventions? _____