PROSTATE CANCER

SCREENING FORM

PERSONAL INFORMATION

Full Name :

Age :

Date of Birth : D D M M Y Y

Race :

E-mail :

Phone Number :

FAMILY HISTORY

Family history of prostate cancer? Yes No

Family history of ovarian, breast, or pancreatic cancer? Yes No

PERSONAL MEDICAL HISTORY

When was your last prostate-specific antigen (PSA) test or digital rectal exam (DRE)?

Do you experience frequent urination, difficulty starting or stopping urination, weak urine flow, or pain during urination? Yes No

Have you noticed any changes in your sexual function, such as erectile dysfunction or painful ejaculation? Yes No

THANK YOU FOR YOUR INFORMATION