Weill Cornell Imaging

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*Please complete **MRI General Safety Form** in addition to this form*

(office use)

MRI: PROSTATE FORM

Name: ______________________________ Date: __________ Age: __________

Why are you having this study? ______________________________

____

Please check all that apply to you (and answer questions below):

- ☐ Pelvic pain
- ☐ Blood in urine
- ☐ Pain with urinating
- ☐ Difficulty urinating
- ☐ Prostatitis
- ☐ Other symptoms (please describe): ______________________________

What is your most recent PSA level? ____________________ Date: __________

Have you had a PCA3 test? ☐ Yes ☐ No

If yes, what were the results? ______________________________

Have you had a prostate biopsy? ☐ Yes ☐ No

If yes, when? __________ What were the results? ____________________

Have you had a prior prostate MRI? ☐ Yes ☐ No

If yes, when? __________ Where? ____________________

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

If yes, what type (check all that apply)?

- ☐ Hormone treatment
- ☐ Surgery
- ☐ Radiation
- ☐ Radiation seed implants
- ☐ Cryoablation
- ☐ Radiofrequency ablation
- ☐ Focused ultrasound ablation

Any other relevant symptoms? ______________________________