Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

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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? _____