McLaren

CARO REGION

ULTRASOUND PROSTATIC EVALUATION

Patient Name :_____ **DATE:** _____

AGE :_____ **MR# :**_____ **REFERRING PHYSCIAN:** _____

Previous Prostate History:

Digital Rectal Exam ☐ Yes:_____

☐ No

Surgery ☐ Yes:_____

☐ No

Biopsy ☐ Yes:_____

☐ No

Prostate Cancer Hx

Self ☐ Yes:_____

☐ No

Family ☐ Yes:_____

☐ No

Indications For Exam:

Nocturia

☐ Yes:_____

_____

☐ No

Incontinence

☐ Yes:_____

☐ No

Problems Urinating

☐ Yes:_____

_____

_____

☐ No

PSA :_____

Comments:

_____

Sonographer:_____

FORM: US 14

NEW: 10-4-19