



A Publication of the Prostate Cancer Education Council

Screening Questionnaire

INSTRUCTIONS (PLEASE READ):

- Use dark BLUE or BLACK pen
- Mark checkboxes clearly
- Write within boxes using CAPITAL letters

T H I S I S A S A M P L E

16. Do you have a family history of any of these conditions?

- Prostate Cancer Was it your: Father Grandfather
 Brother Uncle

	Parent	Sibling	Extended Family
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you have a history of seizure disorders?

- Yes No

18. Why are you attending this screening program?

- I think I am at high risk
 I am very health conscious
 I am interested in overall men's health
 My wife insisted
 I am interested in other prostate conditions
 I want to be certain I don't have prostate cancer
 I have a family history of prostate cancer
 Other _____

▼▼▼▼▼ URINARY SYMPTOMS EVALUATION ▼▼▼▼▼

Over the past month, have you had any of the following problems with your urination?

19. How often have you had a sensation of not emptying your bladder completely after you finish urinating? Not at all Less than half More than half
 Less than 1 in 5 Half the time Almost always
20. How often have you had to urinate again less than two hours after you finish urinating? Not at all Less than half More than half
 Less than 1 in 5 Half the time Almost always
21. How often have you found that you stopped and started again several times when you urinate? Not at all Less than half More than half
 Less than 1 in 5 Half the time Almost always
22. How often have you found it difficult to postpone urination? Not at all Less than half More than half
 Less than 1 in 5 Half the time Almost always
23. How often have you had a weak urinary stream? Not at all Less than half More than half
 Less than 1 in 5 Half the time Almost always
24. How often do you push or strain to begin urination? Not at all Less than half More than half
 Less than 1 in 5 Half the time Almost always
25. How many times do you get up to urinate from your time to bed until the time you get up in the morning? Never Twice Four times
 Once Three times Five or more times
26. If you spent the rest of your life with your urinary condition just the way it is now, how would you feel? Delighted Mostly satisfied Mostly dissatisfied Terrible
 Pleased Mixed about it Unhappy



▼▼▼▼▼ LOW TESTOSTERONE TEST (To be completed by PARTICIPANT) ▼▼▼▼▼

27. Do you have a decrease in libido (sex drive)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Do you have a lack of energy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. Do you have a decrease in strength and/or endurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30. Have you lost height?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31. Have you noticed a decreased "enjoyment of life"?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32. Are you sad and/or grumpy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33. Are your erections less strong?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34. Have you noticed a recent deterioration in your ability to play sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
35. Are you falling asleep after dinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
36. Has there been a recent deterioration in your work performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered YES to any question 27 or 36, or at least three (3) of the other questions, you may have low testosterone. Fortunately, there is something you and your doctor can do to help. Be sure to discuss this information with your doctor.

Source: Saint Louis University Androgen Deficiency in Aging Men (ADAM) Questionnaire. John Morley, MD., Saint Louis School of Medicine, June 1997

▼▼▼▼▼ SEXUAL HEALTH INVENTORY ▼▼▼▼▼

(Completed by the PARTICIPANT and based on any medications, if taken, at the time)

37. How do you rate your confidence that you could get and keep an erection?	<input type="checkbox"/> Very low	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	<input type="checkbox"/> Very high
38. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	<input type="checkbox"/> No sexual activity				<input type="checkbox"/> Sometimes (half the time)
	<input type="checkbox"/> Almost never or never				<input type="checkbox"/> Most times (much more than half)
	<input type="checkbox"/> A few times (much less than half)				<input type="checkbox"/> Almost always or always
39. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	<input type="checkbox"/> Did not attempt intercourse				<input type="checkbox"/> Sometimes (half the time)
	<input type="checkbox"/> Almost never or never				<input type="checkbox"/> Most times (much more than half)
	<input type="checkbox"/> A few times (much less than half)				<input type="checkbox"/> Almost always or always
40. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	<input type="checkbox"/> No sexual activity				<input type="checkbox"/> Difficult
	<input type="checkbox"/> Extremely difficult				<input type="checkbox"/> Slightly difficult
	<input type="checkbox"/> Very difficult				<input type="checkbox"/> Not difficult
41. When you attempted sexual intercourse, how often was it satisfactory for you?	<input type="checkbox"/> Did not attempt intercourse				<input type="checkbox"/> Sometimes (half the time)
	<input type="checkbox"/> Almost never or never				<input type="checkbox"/> Most times (much more than half)
	<input type="checkbox"/> A few times (much less than half)				<input type="checkbox"/> Almost always or always
42. If you have or get Erectile Dysfunction (ED), would you: (mark all that apply)	<input type="checkbox"/> Discuss it with my doctor				<input type="checkbox"/> Take prescription medication
	<input type="checkbox"/> Take herbs/supplements				<input type="checkbox"/> Other _____
	<input type="checkbox"/> Do nothing				
43. If you have or get BPH/EP, would you (mark all that apply):	<input type="checkbox"/> Discuss it with my doctor				<input type="checkbox"/> Take prescription medication
	<input type="checkbox"/> Take herbs/supplements				<input type="checkbox"/> Other _____
	<input type="checkbox"/> Do nothing				



▼▼▼▼▼ MEDICATIONS ▼▼▼▼▼

Are you currently on any of the following medications? Please mark below.

44. Testosterone Replacement Therapy? If yes, how many days/months? _____ Days _____ Months

- None
 Androgel (gel)
 Testim (gel)
 Androderm (patch)
 Restorin (skin patch)
 Testosterone injections
 Oral testosterone
 Other, including over-the-counter _____

45. Cholesterol lowering medications? If yes, how long? _____ Days _____ Months

- None
 Lipitor (atorvastatin)
 Tricor (fenofibrate)
 Pravachol (pravastatin)
 Lopid (gemfibrozil)
 Mevacor (lovastatin)
 Zocor (simvastatin)
 Vytorin (ezetimibe/simvastatin)
 Crestor (rosuvastatin)
 Zetia (ezetimibe)
 Lescol (fluvastatin)
 Niaspan (niacin)
 Other _____

46. Are you currently taking prescription medication for an overactive bladder?

- None
 Sanctura
 VESicare
 Enablex
 Ditropan
 Oxytrol
 Detrol LA
 Other _____

47. Are you taking prescription medications for urinary problems? (mark all that apply)

- None
 Cardura
 Flomax
 Uroxatral
 Proscar
 Hytrin
 Avodart
 Other _____

48. If you were diagnosed with localized prostate cancer, how would you choose to be treated?

- Brachytherapy/seeds
 Hormone therapy only
 Surgery
 Watchful Waiting
 Radiation
 Other _____

49. If you have or get Erectile Dysfunction (ED), are you taking any of the following? (mark all that apply)

- Viagra
 Cialis
 Levitra
 Herbs/supplements
 Other _____

50. Blood pressure, if known, from last doctors visit: _____ / _____



THE PROSTATE CANCER EDUCATION COUNCIL

The Prostate Cancer Education Council is a 501-3c non-profit organization that has been coordinating Prostate Cancer Awareness Week (PCAW) for over a decade. The Council is made up of respected medical doctors, researchers and professionals dedicated to the research and educational efforts designed to reduce and maybe one day eliminate the threat of Prostate Cancer.

PROSTATE CANCER AWARENESS WEEK

PCAW is a program that coordinates hospitals, clinics, physicians, health centers and other organizations so they can provide free or low-cost prostate cancer screenings. The commitment and cooperation of thousands of people across America make Prostate Cancer Awareness Week possible.

Prostate Cancer Awareness Week was initiated in 1989. Today, nearly 60 percent of new cases of prostate cancer are localized and potentially curable, indicating a dramatic increase in awareness among the general population about the importance of early detection. Aside from screening millions of men, PCAW has also yielded valuable information on several important research issues.

THE PROSTATE CANCER EDUCATION COUNCIL HAS PROVIDED FREE SCREENINGS TO OVER 3 MILLION MEN. THIS PROGRAM IS FUNDED SOLEY THROUGH GENEROUS CONTRIBUTIONS LIKE YOURS. MAKE YOUR TAX DEDUCTIBLE DONATIONS ONLINE AT: WWW.PCAW.COM OR TO:

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More Information

Visit our website for more information regarding prostate cancer screenings in your area, Prostate Cancer Awareness Week, support groups, current prostate cancer research and events sponsored by the Prostate Cancer Education Council.

www.PCAW.com

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