CAYMAN ISLANDS CANCER SOCIETY

PSA Voucher Questionnaire

TODAY'S DATE: _____

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Age: ____
mm/dd/yy

Mailing Address: _____

Phone (home): _____ (office): _____ (cell): _____

Fax: _____ E-mail: _____

Doctor's Name: _____ (Phone): _____

Medical Insurance Provider: _____ Plan Type: _____

1. When did you last have a complete medical exam by a doctor? _____

2. Have you ever had a rectal exam? YES When? _____ NO

3. Have you ever had a PSA blood test done? YES When? _____ NO
   Did your doctor tell you the results were not normal? YES NO

4. Have you ever had any of the following?

Prostate Infection	YES	NO	If YES, When? _____
Enlarged Prostate	YES	NO	If YES, When? _____
Prostate Cancer	YES	NO	If YES, When? _____
Any other cancer	YES	NO	If YES, When? _____
Vasectomy	YES	NO	If YES, When? _____

5. Have you noticed any of the following changes in your urinary patterns? Please tick all that apply.
   - ☐ Frequent urination
   - ☐ Feeling of not emptying bladder completely
   - ☐ Weak or interrupted flow of urine
   - ☐ Blood pus in your urine or semen
   - ☐ Weak urinary stream
   - ☐ Pain or stiffness in your lower back, hips or pelvis
   - ☐ Inability to urinate
   - ☐ Incontinence (inability to hold your urine)
   - ☐ Painful or burning sensation during urination
   - ☐ Stopping & starting while urinating
   - ☐ Painful ejaculation

6. How often do you get up at night to urinate? _____

7. Have you ever had any treatment to your prostate? YES NO

   Please explain: _____

PLEASE TURN OVER

PSA Voucher Questionnaire

8. Do you take any medications? YES NO

   Please list: _____

9. Do you have a personal history of cancer? YES NO

   If YES please state type of cancer & year of diagnosis: _____

10. Is there a family history of cancer YES NO

    If YES please state the relative(s), and type of cancer _____

    _____

PSA BLOOD TEST CONSENT FORM

I, _____, give consent to have my blood drawn and
(please print name here)

understand that my PSA (Prostate Specific Antigen) level will be tested with this sample. The results of this test will be sent to my doctor, whose name I will provide. In the event that I do not have a regular physician, or do not provide a physician's name, the results will be sent to the Medical Director of the Cayman Islands Cancer Society, who will contact me with said results.

I also agree to waive all rights of action or any claims that I may have against the Cayman Islands Cancer Society, The Lions Club of Grand Cayman, Movember Committee, Baptist Health International, TrinCay Medical Centre & Urgent Care, Med Lab, CTMH, Cayman Health Lab or Seven Mile Clinic as a result of doing this test.

By signing this form I also acknowledge that I have read and understood the information provided regarding this test's use and its limitations.

_____ _____

Signature Date