Prostate Cancer Screening NB

Name: Date of Birth (D/M/Y):

Pharmacy: Family Dr:

Do you have or have you ever had (**check all that apply**):

- ☐ COPD
- ☐ Shortness of breath at rest or with minimal activity
- ☐ Heart valve or rhythm problems
- ☐ Heart attack, angina, or heart stents
- ☐ Heart failure
- ☐ Diabetes
- ☐ Liver problems
- ☐ Stroke or mini-stroke
- ☐ Serious neurologic (brain and nerve) problems
- ☐ Blood clots
- ☐ Other (describe):

Has a father or brother had prostate cancer? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

Please list any surgeries you have had:

Please list any medications you take on a daily basis: