

**Human Resources Center, Inc.**  
**ANNUAL PROSTATE EXAMINATION**

*Required every year for men 40 years of age or older.*

TO BE COMPLETED BY PROVIDER:

Name of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

\*ALLERGIES\*: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff Signature: \_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN:

Diagnosis of Prostate Exam: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescribed Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*The Prostate Antigen Test (PSA) to measure Antigen in the blood is NOT acceptable in place of the Prostate Exam.*

\_\_\_\_\_  
Physician's Signature