Pregnancy Screening Form

(Ages 12-55 years)

Patient Name: _____ Age: _____

1.) Are you pregnant or do you think you may be pregnant? _____ Y _____ N
(If "yes", please notify staff immediately).

2.) Have you had a hysterectomy or are post-menopausal? _____ Y _____ N
(If "yes", please sign below).

3.) Have you had a menstrual period within the last 30 days? _____ Y _____ N
(If "no", you will need to have a pregnancy test).

4.) Please give the date of the 1st day of your last menstrual period. _____

5.) Does this date fall within the last 10 days? _____ Y _____ N
(If "yes", please sign below).

6.) Are you currently practicing any of the following birth control? _____ Y _____ N

A.) Tubal Ligation _____
B.) Partner Vasectomy _____
C.) Oral Contraceptives _____
D.) Condom _____
E.) Diaphragm _____
F.) Foam _____
G.) IUD _____
H.) Other _____

7.) **If you are NOT practicing any birth control measures, have you had sexual activity since your last menstrual period that may put you at risk of pregnancy?** _____ Y _____ N

I have stated that I am NOT pregnant and request the ordered Imaging procedure be performed.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NAME: [PatientLast], [PatientFirst]
ACT#: [PatientId] GENDER: [Sex]
DOB: [DOB] AGE: [Age]
DR: [PhyLast], [PhyFirst]
DOS: [DOS]