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]