MESQUITE DIAGNOSTICS at DALLAS REGIONAL

# Radiology Pregnancy Questionnaire

Name: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____

To All Women of Child-Bearing Age ( 10-55 Years)

We are asking you to complete this form to avoid the inadvertent exposure of an early pregnancy to harmful radiation. Depending on the type and urgency of the examination requested for you, additional precautions may be necessary. Please be truthful and feel free to ask questions or offer additional information.

| | | |
|---|---|---|
| HAVE YOU BEEN THROUGH MENOPAUSE? (Circle your answer) | YES | NO |
| BEGINNING DATE OF YOUR LAST MENSTRUAL CYCLE (PERIOD) | _____ | |
| DO YOU THINK YOU COULD BE PREGNANT? | YES | NO |
| HAVE YOU HAD A HYSTERECTOMY? | YES | NO |
| HAVE YOU HAD YOUR TUBES TIED? (TUBAL LIGATION) | YES | NO |
| HAVE YOU TAKEN BIRTH CONTROL PILLS CONSISTENTLY FOR 3 MONTHS? | YES | NO |
| ARE YOU GETTING DEPO PROVERA INJECTIONS? | YES | NO |
| HAS YOUR PARTNER HAD A VASECTOMY? | YES | NO |
| HAVE YOU BEEN SEXUALLY ACTIVE SINCE YOUR LAST MENSTRUAL CYCLE (PERIOD) ? | YES | NO |
| ARE YOU USING SOME OTHER FORM OF BIRTH CONTROL OR PROTECTION? IF SO, PLEASE LIST BELOW | YES | NO |

_____

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____
(PATIENT/PARENT SIGNATURE) (DATE)

_____
(TECHNOLOGIST SIGNATURE)

ACTION TAKEN, IF ANY (SHIELDING, PREGNANCY TESTING, ETC)

_____