PREGNANCY QUESTIONNAIRE & ATTESTATION

This informational questionnaire is designed for female patients between the ages of **12 and 50, inclusive,** who are requested to undergo radiological procedures of the **abdomen, pelvis, hips and/or proximal femur, or any MRI or Nuclear Medicine exams.** These radiological exams, performed during pregnancy, may subject the developing embryo or fetus to potentially harmful effects of ionizing radiation or strong magnetic fields and radiofrequency energy. Radiology Imaging Associates has adopted guidelines established by the National Council on Radiation Protection and Measurements, which recommend that x-ray exams be performed only during the 14 days following the onset of menstruation to prevent exposure to a developing pregnancy. Certain factors, however, may allow these exams to be performed outside of these 14 days.

In order to assess the possibility of your being pregnant, Radiology Imaging Associates asks that you provide us with the following information prior to undergoing these procedures. We regret that these questions must be of a very personal nature, but your truthful answers are necessary to help us determine the likelihood of pregnancy. If you strongly object to providing this information, please let us know and we may arrange a pregnancy test instead. Thank you.

HAVE YOU HAD A HYSTERECTOMY (UTERUS REMOVED)? YES _____ NO _____

HAVE YOU HAD A TUBAL LIGATION (BOTH TUBES TIED)? YES _____ NO _____

HAVE YOU HAD PERMANENT CONFIRMED TUBAL OCCLUSION?

(Essure or Adiana) YES _____ NO _____

HAVE YOU HAD BOTH OVARIES SURGICALLY REMOVED? YES _____ NO _____

ARE YOU PRESENTLY TAKING BIRTH CONTROL PILLS? YES _____ NO _____

ARE YOU USING THE NORPLANT IMPLANT FOR BIRTH CONTROL? YES _____ NO _____

ARE YOU USING THE ORTHO-EVRA PATCH FOR BIRTH CONTROL? YES _____ NO _____

HAVE YOU HAD THE DEPO-PROVERA INJECTION IN LAST 90 DAYS? YES _____ NO _____

HAVE YOU REACHED MENOPAUSE? YES _____ NO _____

ON WHAT DATE DID YOUR MOST RECENT MENSTRUAL PERIOD BEGIN? _____

WAS IT OF NORMAL DURATION AND FLOW? YES _____ NO _____

ARE YOU BREAST FEEDING? YES _____ NO _____

PLEASE INFORM US OF ANY OTHER REASON WHY YOU <u>COULD NOT BE</u> PREGNANT.

REASON: _____

Please provide your name, today's date and your signature below, to indicate that you have provided the above information willingly and to the best of your knowledge.

_____ _____

Print Your Name Date

_____ _____

Signature of Patient/Legal Guardian Witness