

DATE _____

X-RAY NO. _____

FOR ELECTIVE SCHEDULING OF RADIOLOGY PROCEDURE, THIS FORM MUST BE COMPLETED FOR / BY ALL FEMALES BETWEEN THE AGES OF 12 AND 50 OF AGE. WE MAKE EVERY EFFORT TO MINIMIZE RADIATION EXPOSURE IN ALL PATIENTS; HOWEVER, IF THERE IS ANY CHANCE THAT YOU COULD BE PREGNANT, SPECIAL LEAD SHIELDING MAY BE NECESSARY OR YOUR EXAMINATION DELAYED UNTIL YOU ARE NOT PREGNANT.

(PARA RADIOGRAFIAS ELECTIVAS, ESTE QUETIONARIO DEBE DE SER COMPLETADO POR TODAS LAS MUJERES DE 12 A 50 ANOS DE EDAD. NOSOSTROS HACEMOS EL ESFUERZO DE USAR RADIACION MINIMA EN TODOS LOS PACIENTES. EN CASO DE QUE USTED ESTE EMBARAZADA O HAY POSIBILIDAD DE PEUEDD ESTAR EMBARAZADA PROTECCION ESPECIAL ES NECESARIA O SU EXAMEN PUEDE SER ATRAZADO HASTA QUE USTED NO ESTE EMBARAZADA.)

- (NOMBRE) _____ (EDAD) _____
 1. NAME _____ AGE _____
 YES (SI) NO (NO)
2. HAVE YOU HAD HYSTERECTOMY? _____
 (HA TEENIDO HISTERECTOMIA?) _____
- OR ALREADY GONE THROUGH MENOPAUSE? _____
 (MENOPAUSA?) _____
3. BEGINNING OF LAST MENSTRUAL PERIOD: _____ / _____ / _____
 (PRINCIPIO DE SU ULTIMO PERIODO) MONTH (MES) DAY (DIA) YEAR (AND)
4. ARE YOU ON ANY TYPE OF BIRTH CONTROL? YES (SI) _____ NO (NO) _____
 (ESTA USTED USANDO ALGUN TIPO DE ANTI - CONCEPTIVO?)

- IF "YES" PLEASE CHECK BELOW:
 (SO LO ESTA USANDO, POR FAVOR INDIQUE EL METODO?)
- | | | YES (SI) | NO (NO) |
|--------------------------|------------------------------------|----------|---------|
| A. BIRTH CONTROL PILLS | (USA PASTILLAS ANTI - CONCEPTIVAS) | _____ | _____ |
| B. I.U.D. | (TIENDE DISPOSITIVO INTREATERINO) | _____ | _____ |
| C. TUBAL LIGATION | (TIENE LOS TUBOS LIGADOS) | _____ | _____ |
| D. HUSBAND HAD VASECTOMY | (ESPOSP A TENIDO VESECTOMIA) | _____ | _____ |
| E. COMDOMS | (CONDONES) | _____ | _____ |
| F. DIAPHRAGM AND FOAM | (DIAFRAGMA O ESPUMA) | _____ | _____ |
| G. NORPLANT | (TRASPLANTE) | _____ | _____ |
| H. DEPO - PROVERA | (TRAS EN SU CUERPO) | _____ | _____ |
| I. SPERMICIDAL INSEERT | (U SANDO PROTENTION) | _____ | _____ |
| J. PATCH | (REMIENDO) | _____ | _____ |
| K. NONE OF THE ABOVE | (NINGUNO DE LO ANTERIOR) | _____ | _____ |

- IF NONE OF THE ABOVE:
5. HAVE YOU HAD SEX SINCE YOUR LAST PERIOD? YES (SI) _____ NO (NO) _____
 (HA TENIDO RELACIONES DESDE SU ULTIMA REGLA?) _____
6. ARE YOU PREGNANT? MAYBE (QUIZAS) _____
 (ESTA USTED EMBARAZADA?) _____

 PATIENT SIGNATURE (FIRMA DEL PACIENTS) WITNESS
 AUTHORIZATION TO SUSPEND GUIDELINES:

Medical Center of Lewisville

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PREGNANCY QUESTIONNAIRE
(QUESTIONARIO)

Patient Identification