High Tech Imaging Center

PATIENT STATEMENT OF PREGNANCY/NURSING CONDITION

Patient Name:_____

In the interest of safety for unborn children and nursing infants, every female patient of childbearing age *(10yrs-55yrs)* is required to complete applicable portions of the following questionnaire.

NOTE: ALL STATEMENTS ARE CONSIDERED TO BE STRICKLY CONFIDENTIAL.

When was your last menstrual cycle? _____
Are you currently on any type of birth control medicine? Yes___ No___ What type? _____

☼ I am physically unable to become pregnant due to surgical/medical procedures which have been preformed.

_____
Initial if applicable
(If the above is initialed, omit the remaining questions and sign and date at the bottom of the page.)

☼ I am absolutely certain that I am not pregnant.

_____
Initial if applicable

☼ There is some possibility that I might be pregnant, and for this reason, I authorize High Tech Imaging Center to conduct a pregnancy test.

_____
Initial if applicable

☼ I know or believe that I am pregnant.

_____
Initial if applicable

NOTES- *Office Use Only!!*

_____

_____

_____

_____

_____

☼ I am breastfeeding.

_____
Initial if applicable

☼ I am not breastfeeding.

_____
Initial if applicable

Patient Signature: X _____

Date:_____