

## PREGNANCY QUESTIONNAIRE

This form is for the use of married and unmarried women between 12 and 50 years of age who require radiography.

FULL NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

1. What was the date of the **first day** of your last menstrual period? \_\_\_\_\_

2. Is there any possibility that you have incurred a risk of pregnancy beginning **TEN (10) DAYS** after that date? (Please check **NO** if you use a reliable method of birth control.)

\_\_\_\_\_ YES      \_\_\_\_\_ NO

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

