



HYSTEROSALPINGOGRAM INTAKE FORM

Please print legibly

Date: \_\_\_ / \_\_\_ / \_\_\_ Name: Last Name First Name Middle Initial

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Age Height Weight Test Scheduled:

Why did your doctor order this test:

List previous tests performed at Manhattan Diagnostic Radiology and when they were performed:

List previous surgical procedures and date performed:

List any chronic diseases you have:

Do you have a history of kidney disease? Are you HIV or Hepatitis Positive?

Do you have heart disease? If yes, what kind?

Are you Diabetic? If so, are you currently taking Glucophage (Metformin), Avandamet or Glucovance?

Do you have a history of cancer? If yes, when and what type:

Have you ever had Chemotherapy? Radiation Therapy?

If yes, what type and when was your last session:

Do you have any of the following allergies?

Iodine contrast (dye injection)? Latex?

Medication/Food Allergies? If yes, list :

Number of Pregnancies: Children: Miscarriage: Abortions:

Have you ever:

Used an IUD? If yes, how long? :

Had a D & C ? How Many? When?

Had Pelvic Inflammatory disease? Type? When?

Had Pelvic Surgery? Type? When?

Did your mother take DES (to prevent miscarriages) while she was pregnant with you?

Have you had a previous Hysterosalpingogram? If yes, when?

Where? Results?

HYSTEROSALPINGOGRAM CONSENT

I attest that, to the best of my knowledge, the above information is correct. I read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the procedure that I am about to undergo I hereby give authorization for a hysterosalpingogram to be performed on me.

Patient Signature

Patient Name

Date

For patients who have irregular periods or are here more than 12 days after their last menstrual period, if applicable, please sign the following: I understand that there is a small chance that I may be pregnant, nevertheless, I want to have this procedure performed today.

Patient Signature: Date: