# Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

## Radiology Pregnancy Questionnaire

Name _____ DOB_____

To ALL women of child bearing age (10-60 years)

We are asking you to sign this form for each office visit to avoid the inadvertent exposure of an early pregnancy to harmful radiation or magnetic fields. Depending on the type and urgency of the exam requested for you, additional precautions may be necessary. Please be truthful and feel free to ask any questions.

**Do you think you may be pregnant? ☐ YES ☐ NO**

**If answered yes, please notify staff before an X-ray, MRI, or CT is performed!**

**Date of last menstrual cycle (Period) _____**

I have read and understand the above information. I have answered the questions to the best of my knowledge and have been given the opportunity to ask questions.

_____ _____

Patient/Parent Signature Date