

**Prestonwood Imaging Center**

6957 West Plano Parkway, Suite 1100

Plano, Texas 75093

Office 972.395.7533

Fax 972.395.7536

**X-RAY, CT & MRI Pregnancy Questionnaire**  
**for Females Age 10-55 Years**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

To your knowledge, are you pregnant? YES / NO

If so, how far along are you? \_\_\_\_\_  
(Also, **IF YOU ARE PREGNANT**, please notify the technologist and the front desk  
**BEFORE** proceeding with your exam!)

If you are NOT pregnant, when was the date of your last menstrual cycle? \_\_\_\_\_

Are you presently on some method of birth control? YES / NO

If so, please specify the method: \_\_\_\_\_

Have you had a hysterectomy? YES / NO

Have you had a tubal ligation? YES / NO

Are you currently a breast feeding mother? YES / NO

If so, we ask that you do not breastfeed for **48 hours** following the administration of intravenous iodinated (containing iodine) contrast material.

I have answered the above questions to the best of my ability. I have been informed of the potential risks involved **if I am pregnant** from the CT and/or MRI technologists. By signing this authorization form, I am giving my consent to proceed with the CT and/or MRI scan that my referring physician has ordered for me today.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TECHNOLOGIST INITIAL** \_\_\_\_\_