ARA Diagnostic Imaging
HYSTEROSALPINGOGRAM (HSG) FORM

Patient Name: _____ ACC#: _____ MRN: _____

Check One

☐ Yes ☐ No Have you ever had this exam before? If so, when and where:

☐ Yes ☐ No Have you ever been pregnant?
Dates: _____

Number of deliveries: _____

Was it a vaginal birth: _____

☐ Yes ☐ No Are you trying to get pregnant?

☐ Yes ☐ No Have you ever had any pelvic surgeries (D & C, tubal ligation, etc.)?
If so, please list the procedure with the date:

_____

When was the first day of your period? _____

When did your period stop? _____

☐ Yes ☐ No Are you on any fertility drugs?

If so, please list the names: _____

☐ Yes ☐ No Are you on any antibiotics?

If so, please list the names: _____

☐ Yes ☐ No Do you have any allergies?

If so, please list the names: _____

☐ Yes ☐ No Do you have any reason to believe you are pregnant?

☐ Yes ☐ No Have you ever had any recent pelvic imaging, such as ultrasound or x-rays?

Patient Signature: _____ Age: _____ Date: _____

Office Use ONLY

Technologist Initials: _____

Contrast Used: _____

Lot Number: _____