AUSTIN RADIOLOGICAL ASSOCIATION
HYSTEROSALPINGOGRAM (HSG) FORM

Patient Name: **ACC#:** **MRN:**

Circle One

Yes No 1. Have you ever had this exam before? If so, when and where:

_____

Yes No 2. Have you ever been pregnant?

Dates: _____

Number of deliveries: _____

Was it a vaginal birth: _____

Yes No 3. Are you trying to get pregnant?

Yes No 4. Have you ever had any pelvic surgeries (D & C, tubal ligation, etc.)?

If so, please list the procedure with the date: _____

_____

5. When was the first day of your period? _____

6. When did your period stop? _____

Yes No 7. Are you on any fertility drugs?

If so, please list the names: _____

Yes No 8. Are you on any antibiotics?

If so, please list the names: _____

Yes No 9. Do you have any allergies?

If so, please list the names: _____

Yes No 10. Do you have any reason to believe you are pregnant?

Yes No 11. Have you ever had any recent pelvic imaging, such as ultrasound or x-rays?

Patient Signature: _____ **Age:** _____ **Date:** _____

Technologist Initials: _____ ***Office Use ONLY***

Contrast Used: _____

Lot Number: _____

Report Name: HSGFORM