Hysterosalpingogram (HSG) History Form

AdventHealth

TO BE COMPLETED BY THE PATIENT:

What was the date of the first day of your last period?_____

Check the appropriate box:

YES NO

☐ ☐ Are you still "spotting"?

☐ ☐ Is there a possibility you are pregnant?

☐ ☐ Have you engaged in sexual intercourse since the start of your period?

☐ ☐ Have you ever had an ectopic pregnancy?

☐ ☐ Have you had a gynecologic surgery? (i.e. tubal ligation) Specify type: _____

If yes, date of procedure: _____

☐ ☐ Have you ever been pregnant?

If yes, how many times? _____

☐ ☐ Have you ever had Pelvic Inflammatory Disease?

☐ ☐ Do you have any allergies to iodine or imaging contrast?

If yes, date occurred: _____

If yes, describe the reaction: _____

_____

_____	_____	_____	_____/_____
Patient/Authorized person signature	Print name	Title (Self,Spouse,Nurse,etc.)	Date Time
_____	_____	_____	
Interpreter name	ID number	Language interpreted	
_____	_____	_____/_____	
Technologist authentication	OPID	Date Time	

Patient Label or

Patient Name _____

DOB _____ MRN _____