LOWCOUNTRY ORTHOPAEDICS
SPORTS MEDICINE

PRE-EXAMINATION PREGNANCY DETERMINATION

PATIENT NAME: _____ DATE: _____

TIME: _____ CLINICAL STAFF: _____

PREGNANCY CHECK

For female patients of reproductive age (postmenarche to menopause [e.g., age 12-50]), indicate the patient's response to the following 3 questions:

1 **What was the first day of your last complete menstrual period?**

Month _____ Day _____ Year _____

2 **Have you had a Hysterectomy?**

☐ Yes ☐ No

3 **To the best of your knowledge, are you pregnant (or do you think you could be)?**

☐ Yes ☐ No ☐ Possibly / Not sure

How far along: _____ weeks or _____ months

ORDERING PHYSICIAN SIGNATURE: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Thank you for helping us provide safe and appropriate care.