CHIROPRACTIC & WELLNESS

Female Supplemental History Form

Name: _____

Name of OB/GYN physician _____

Phone Number of Physician (_____)_____

Date of last OB/GYN exam _____ Was a Pap smear done? ____ Yes or ____No

Were the results of your last OB/GYN exam and Pap normal? ____ Yes ____ No ____ Unsure

Have you ever had a miscarriage? _____ Yes_____ No

Are you pregnant? _____ Yes_____ No

Is there a chance you might be pregnant? _____ Yes_____ No

Are you late with your menstrual period?_____ Yes_____ No

When did your last period begin? Date: _____/_____/_____

Are you taking oral contraceptives? _____ Yes_____ No

Do you have an IUD? _____ Yes_____ No

Do you have irregular cycles? _____ Yes_____ No

PREGNANCY WARNING AND CONSENT TO X-RAY

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that if there is a chance that I might be pregnant, the 10 days following onset of a menstrual period are generally considered to be the safest time for an x-ray examination.

With full understanding of the above, and believing that I am not currently at risk, I give the doctors of Petry Chiropractic & Wellness, LLC the permission to perform an x-ray examination on me if they feel it is necessary.

Patient Signature: _____ Date: _____