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| <input type="checkbox"/> Sreenivas Gudimetla, MD, FACC | <input type="checkbox"/> Brandie D. Williams, MD, FACC | <input type="checkbox"/> Dale Arocha, PA-C |
| <input type="checkbox"/> Joseph M. Ortenberg, MD, FACC | <input type="checkbox"/> Carl J. Horton, MD, FACC | <input type="checkbox"/> Robbin Quillin, RN, MSN, AGACNP |
| <input type="checkbox"/> Theodore S. Takata, MD, FACC | <input type="checkbox"/> Nathan J. Lo, MD | |

OVERALL PREGNANCY RISK

Within the Healthcare field, ionizing radiation (the use of radiopharmaceuticals or x-ray) has been recognized as potentially harmful to a fetus. Even though, the likelihood of such an injury is slight our facilities would like to make you aware of any possible dangers. At the discretion of your physician the information gained from this Nuclear Medicine Stress Test may be primarily important to your overall health.

PREGNANCY QUESTIONNAIRE

Your physician has ordered a nuclear medicine stress test. This examination includes the use of ionizing radiation (radiopharmaceuticals). To prevent radiation exposure to a fetus/unborn child, Texas Health Heart & Vascular Specialists request that you answer the questions below to the best of your knowledge. This document is to be completed by all female patients between the ages of 11-55 years of age.

Is there a possibility you may be pregnant? Yes No
 If yes, are you breast feeding? Yes No

List the first day of your last menstrual _____ / _____ / _____ N/A

Below, please check any of the following that apply.
 Menopause Birth Control/IUD Tubal Ligation
 Hysterectomy Vasectomy Other _____

Nuclear Medicine Consent

I _____, here by authorize the performance of a diagnostic Nuclear Medicine Stress Test examination of myself which my physician(s) may consider medically necessary to my overall health.

 Patient or Legal Representative Signature Patient or Legal Representative Printed Name Date Time

 If the patient is a minor, relationship to patient

 Witness Signature (staff member) Witness Printed Name Date Time