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Pregnancy and/or Breast-Feeding Verification
For Patients Having Nuclear Stress Testing

Must be completed by ALL female patients

Patient Name: _____

Birth Date: _____

1. **Are you (check appropriate box):**

   ☐ Post-menopausal

   ☐ Pre-menopausal, surgically sterile (e.g. hysterectomy, tubal ligation, etc.)

   ☐ Pre-menopausal, not surgically sterile

   If so, are you or do you think you may be pregnant? ☐ Yes ☐ No

   Date of your last menstral period: _____

2. **Have you ever had a mastectomy? ☐ Yes ☐ No**

   ☐ Right ☐ Left ☐ Implant ☐ Prosthesis

3. **Are you currently breast-feeding: ☐ Yes ☐ No**

Patient Signature: _____ **Date:** _____