

SCHAFFER, SCHONHOLZ & DROSSMAN, LLP

488 Madison Avenue • New York, NY 10022

Tel. (212) 755-7656 • Fax (212) 688-9474

Patient's Name: _____ Date: _____

Date of Birth: _____ Account Number: _____

SONOHYSTEROGRAPHY QUESTIONNAIRE/CONSENT

1. First day of your last menstrual period: _____/_____/_____
2. Are you pregnant? Yes No
3. Have you ever used an IUD? Yes No
4. Have you had a "D&C", abortion, or uterine biopsy within the last four weeks? Yes No
5. Have you ever had an infection of the uterus and fallopian tubes known as Pelvic Inflammatory Disease? Yes No
If yes, when was the last time you had an infection? _____/_____/_____
6. Are you currently on blood thinners, such as Coumadin? Yes No
7. Have you ever had your tubes tied (tubal ligation)? Yes No
8. Are you on hormone replacement therapy? Yes No
9. Are you allergic to latex? Yes No

PATIENT CONSENT

I hereby request and give authorization to Lyris A. Schonholz, M.D. to perform a sonohysterogram on me. I understand that this procedure, which was requested by my physician, involves the instillation of a small amount of fluid into the uterus for the purpose of determining the status of the uterine cavity. The sonohysterogram procedure has been explained to me and I understand that this procedure may cause pain, bleeding and, occasionally, pelvic infections. I am also aware that any medical procedure can cause adverse consequences not ordinarily anticipated. All of my questions have been answered to my satisfaction and I request and consent to the procedure.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____