NUCLEAR MEDICINE ASSOCIATES

Thyroid Scan Questionnaire

OFFICE USE ONLY
MR#_____
PACS#_____
DOB_____
DATE OF STUDY_____

Name:_____ **Age:** _____ **Referring Physician:**_____

-Have you ever had a thyroid scan before? YES NO

If yes when and where was it performed?_____

Females are you pregnant, possibly pregnant, or breast feeding? **YES NO**

-Are you experiencing any of the following symptoms?

Neck fullness/swelling	YES	NO
Difficulty swallowing	YES	NO
Eye Prominence/double Vision	YES	NO
Excessive nervousness/irritability or shakiness	YES	NO
Heart racing or pounding while relaxing	YES	NO
Excessive sweating or feeling warm	YES	NO
Hoarseness/neck pain/swollen lymph glands	YES	NO

-What is your current weight?_____ Have you gained or lost (please circle) more than 5 lbs. in the last 6 months?

YES NO

-Have you ever had radiation treatment to your head or neck?	YES	NO
-Are you currently on any thyroid medications?	YES	NO
-Have you had any thyroid surgeries?	YES	NO
- Do you have a family history of thyroid can or disease?	YES	NO

-In the last 6 months have you had any of the following X-RAY studies?

____Gallbladder ____Myelogram ____Bronchogram _____Kidney (IVP)
____Lymphangiogram ____CT Scan with Iodinated Contrast ____Arteriogram

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6 HR UPTAKE_____24 HR UPTAKE_____
Exophthalmos _____
Pulse_____
BP _____
T3_____
T4_____
T7_____
TSH_____