NUCLEAR MEDICINE THYROID PATIENT QUESTIONNAIRE

This information will remain confidential and assist the Radiologist in providing a more thorough report.
This procedure involves a radioactive injection followed by a delay of 15-20 minutes before the scan. The scan takes approximately 15 minutes.

NAME: ______________________________ **DATE OF BIRTH:** ______________

Female patients: Are you breast feeding? **YES** **NO** Are you pregnant? **YES** **NO**

1. Have you had ultrasound of your thyroid? **YES** **NO**

   If YES, where ______________________________ and when ______________

2. Have you had any thyroid blood tests? **YES** **NO**

   If YES please give details: OVERACTIVE UNDERACTIVE NORMAL ______________

3. Have you ever had thyroid disease or thyroid surgery in the past? **YES** **NO**

   If YES please give details ______________________________

   ____

4. Is there a history of thyroid disease or surgery in your family? **YES** **NO**

   If YES please give details ______________________________

   ____

5. Do you take any thyroid medications? **YES** **NO**

   If YES please give details ______________________________

   ____

6. Have you ever had any radiation therapy or iodine therapy to your thyroid or neck? **YES** **NO**

   If YES please give details ______________________________

   ____

7. Have you ever had any diagnostic tests involving IV CONTRAST (X-RAY DYE)? **YES** **NO**

   If YES please give details ______________________________

   ____

8. Do you have a diet high in KELP / SEAWEED / IODINE? **YES** **NO**

   If YES please give details ______________________________

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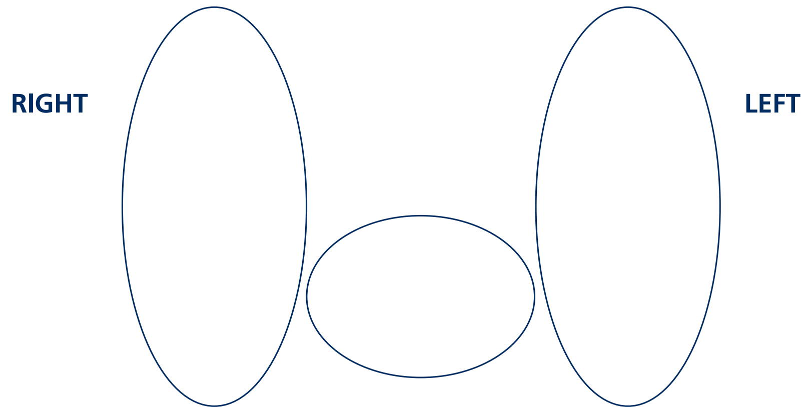
9. Do you have any lumps in your neck? **YES** **NO**

   IF YES, How long have you noticed it?____

   Where in your neck are they? (Please draw)



10. Do you have any of the following symptoms:

Sore Throat	**YES**	**NO**
Tender to Touch	**YES**	**NO**
Trouble Swallowing	**YES**	**NO**
Trouble Breathing	**YES**	**NO**
Tiredness	**YES**	**NO**
Nervous / Anxious	**YES**	**NO**
Excessive Perspiration	**YES**	**NO**
Absence of Perspiration	**YES**	**NO**
Loss of Appetite	**YES**	**NO**
Excessive Appetite	**YES**	**NO**
Significant Weight Change	**YES**	**NO**
Change in bowel habits	**YES**	**NO**
Irregular Menstruation	**YES**	**NO**