Nuclear Medicine Associates
1950 Court Street
Redding, CA 96001
(530) 225-8008

Thyroid Scan Questionnaire/Examination

NAME_____AGE_____DATE_____

PHONE_____ YOUR DOCTOR'S NAME_____

1. Have you ever had a thyroid scan? When_____ _____YES_____NO
   Where_____

2. Are you experiencing any of the following symptoms?
   Neck fullness/swelling or difficulty swallowing..... _____YES_____NO
   Eye prominence/pain or 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 or swollen lymph glands .....YES_____NO

3. Your weight _____lbs. Have you gained or lost more than 5 lbs. in the last six months?.....YES_____NO

4. Have you had radiation treatment to the neck or head .....YES_____NO

5. Are you taking thyroid medication.....YES_____NO

6. In the last 6 months have you had any of the following X-ray studies:
   ____Gall Bladder ____Myelogram ____Bronchogram
   ____Kidney (IVP) ____Lymphangiogram ____CT scan
   ____Arteriogram ____Other:_____

7. Have you had any thyroid surgeries.....YES_____NO

8. <u>These 2 questions are for female patients only</u>:
   -Are you now, or could you possibly be pregnant.....YES_____NO
   -Are you breast feeding.....YES_____NO

DO NOT WRITE BELOW LINE

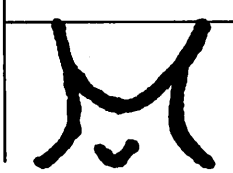
History:_____

_____

_____

Exophthalmos_____
Pulse _____
T3 RU_____ Normal_____
T4_____ Normal_____
T7_____ Normal_____
TSH _____ Normal_____

THYROID EXAMINATION



Approx. gland wt._____