



"The Leader in Quality Medical Imaging"

Label

## Thyroid Uptake & Scan Patient History Form

### HISTORY

Symptoms and reason your doctor ordered this exam: \_\_\_\_\_  
\_\_\_\_\_

Have you had an Ultrasound on your thyroid/neck area before? **Yes No**

If yes, where was it done? \_\_\_\_\_

Have you ever had any treatment or surgery on your thyroid? **Yes No**

If yes, where & when: \_\_\_\_\_

Have you ever had radiation treatments of your thyroid? **Yes No**

If yes, explain: \_\_\_\_\_

In the last three months have you had any radiology procedures that involved the injection of an iodine contrast? **Yes No** If yes, when: \_\_\_\_\_

Have you had blood work done on your thyroid? **Yes No**

Did the doctor tell you anything about the function of your thyroid?  
\_\_\_\_\_

### MEDICATIONS

List all medications you take: \_\_\_\_\_  
\_\_\_\_\_

### SYMPTOMS (Please circle all that apply)

**Weight Loss   Hair Loss   Finger Tremors   Nervousness   Palpitations**  
**Heat Intolerance   Cold Intolerance   Lumps in Neck   Difficulty Swallowing**  
**Hoarseness   Tenderness in Neck Area   Poor Sleep   Dry Skin   Cramps**  
**Fatigue   Weight Gain   Tingling in Hands or Feet   Changes in Menstruation**

(Female Patients)

Is there any chance that you could be pregnant? **Yes No** Are you menopausal? **Yes No**  
Are you currently breast-feeding? **Yes No** Last menstrual Period: \_\_\_\_\_

Patients Initials: \_\_\_\_\_

Tech Initials: \_\_\_\_\_