

PATIENT THYROID QUESTIONNAIRE

UPDATED: MARCH 2010

NAME _____

EXAM _____

MR # _____

DATE _____

PLEASE ANSWER THE FOLLOWING QUESTIONNAIRE.

A technologist will be able to help answer any questions if necessary.

1. What are your current symptoms? _____

2. Have you ever had:

	NO	YES
a. Prior thyroid problems?		
b. Any thyroid tests?		
c. c. Thyroid Hormone Replacement Therapy? (i.e. levothyroxine/synthroid)		
d. Thyroid surgery?		
e. X-ray studies with CONTRAST in the past 6 weeks? (i.e. CT scan w/IV contrast, kidney studies, myelogram/arteriogram)		
f. Radiation therapy to the head, neck, or chest?		

If you answered yes, to any of the above questions, please explain.

3. Do you eat large amounts of sea food, kelp, or health foods?

4. What medications are you presently taking?

FOR WOMEN ONLY:

Date of onset of first day of last menstrual cycle: _____

Usual length of cycle: _____ days

I am pregnant: ____ No ____ Yes ____ Attempting

Is there any reason you could not possibly be pregnant? _____

I am currently breast-feeding: ____ No ____ Yes.

PATIENT SIGNATURE

DATE

TECHNOLOGIST SIGNATURE

DATE