McLaren
CARO REGION

NUCLEAR MEDICINE DEPARTMENT
THYROID INFORMATION SHEET

PATIENT NAME: _____DATE_____

X-RAY #: _____ DOB: _____ AGE: _____

PROCEDURE: _____

DIAGNOSIS: _____

ORDERING PHYSICIAN: _____

Family history of thyroid disease	Yes _____	No _____
Weight loss or gain	Yes _____	No _____
Nervousness	Yes _____	No _____
Hair loss	Yes _____	No _____
Heart palpitations	Yes _____	No _____
Heat or cold intolerance	Yes _____	No _____
Fatigue	Yes _____	No _____
Problems swallowing	Yes _____	No _____
Voice changes	Yes _____	No _____
Difficulty sleeping	Yes _____	No _____
Change in appetite	Yes _____	No _____
Pain or tenderness in neck	Yes _____	No _____
Radiation therapy to face or neck	Yes _____	No _____
Have you had a contrast study in the past 8 weeks	Yes _____	No _____
Are you currently taking thyroid medication	Yes _____	No _____
Have you had a recent thyroid ultrasound	Yes _____	No _____

Isotope: I-123 Capsules_

Dose: _____

Time: _____

Technologist: _____