Community Medical Center

Department of Radiology/Nuclear Medicine Division

Thyroid Scan and Uptake Questionnaire

To better serve you and your physician, please take a few minutes to complete this short questionnaire.

Please bring completed questionnaire on the day of your appointment.

Name: ____ DOB:____________

Reason for Procedure: (please check all that apply)

☐ Abnormal blood work (thyroid function tests) ☐ Nodules ☐ Hypothyroidism (underactive)
☐ Hyperthyroidism(overactive) ☐ Enlarged thyroid gland ☐ Neck mass
☐ Evaluation for radioactive iodine treatment ☐ Abnormal findings on CT, MRI or US
☐ Previous history of thyroid disease ☐ Palpitations ☐ Not sure

Symptoms: (please check all that apply)

☐ Excessive sweating
☐ Heat intolerance
☐ Increased bowel movements
☐ Tremors/shakes
☐ Nervousness/agitation
☐ Rapid heart rate/pulse
☐ Weight Loss
☐ Restlessness/difficulty sleeping
☐ Eyes changing - bulging
☐ Depression
☐ Cold intolerance
☐ Constipation
☐ Muscle aches and pains
☐ Sleepiness
☐ Weight gain or difficulty losing weight
☐ Tiredness/weakness/feeling “run down”
☐ Memory loss
☐ Thinning or brittleness of hair or nails

Medication History: (please check all that apply)

Are you currently taking or recently stopped taking any of the following medications for your thyroid?

ANTITHYROID MEDICATIONS

☐ PTU
☐ Tapazole (Methimazole)
☐ Livothyroxine
☐ Carbimazole
☐ Other __________________________

THYROID SUPPLEMENTAL HORMONE

☐ Levothyroxine (Synthroid, Levoxyl, Levo-T, Levothyroid)
☐ Armor thyroid
☐ Thyroxine
☐ Cytomel
☐ Other ______________________________

How long before your appointment did you stop taking the above medication? ______________________

Thank You. A Nuclear Medicine Technologist will review this questionnaire with you.

Technologist’s Notes:

Pregnant? ☐Y ☐N ☐N/A LMP:_____________ **Tech Initials:**__________

Other meds, vitamins, IV contrast or solutions that may interfere with uptake? ______________________________

Did patient bring pertinent outside films, reports and blood work? ☐**Y** ☐**N** . If No, please have patient bring the following day, or technologist should call MD office to fax to department.

Comments: ____

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