FACILITY: _____

THYROID CANCER INFORMATION

PATIENT NAME:_____ **DATE OF EXAM:**____/___/___

1. **What physician referred you here?**_____
   *?Que medica le refirio aqui?*_____
2. **Why did your doctor order this test?**_____
   *?Por que su doctor?*_____
3. **Have you, in the last six months had any of these radiology tests?**
   ?Usted, en los seis meses pasados ha tenido cualesquiera de estas pruebas del radioogy?

_____**Any recent Nuclear Medicine Test** _____ **IVP (Kidney)** _____ **CT**
Cuaquier prueba en Medicine Nuclear *IVP (Rinon)* *CT*

_____**Catheterization** _____ **Angiogram**
Cateterizacion *Angiograma*

THYROID MEDICAL HISTORY:

1. ☐ Yes ☐ No **History of Thyroid Cancer?**

2. Date diagnosed? _____

3. ☐ Yes ☐ No **Surgery?**

4. Date and type of Surgery? _____

5. ☐ Yes ☐ No **Treatment with Radioactive iodine?**

6. Dates of I-131 Treatment?_____
_____

7. ☐ Yes ☐ No **Prior I-131 Scan?**

8. Last scan date:_____
Location:_____

MEDICATIONS-
What medicines do you take?

Cytomel or Lithotronine ☐ Yes ☐ No

Synthroid or Levothyroxin/Levoxol ☐ Yes ☐ No

Thyroid or Armour Thyroid ☐ Yes ☐ No

Date Last Taken _____

Others please list

_____

_____

Additional Comments:_____

_____

Female Patients:

Menstrual History: Last menstrual Period? _____ Any chance of pregnancy? _____
Hysterectomy: When? _____ Menopause? _____

_____
Technologist Signature

THYROID CANCER INFORMATION