MEDICAL IMAGING OF MANHATTAN, LLC

Account # _____ Tech:_____ Date: _____

Thyroid Imaging Worksheet

Name: _____ Age:_____ Date of Birth:_____

Reason for today's exam: (Routine/Follow-up/Medical problem or Complaint):

_____

_____

List previous surgeries: _____

_____

_____

List Current Medications (including hormones, birth control, etc):

_____

_____

Is there a family history of thyroid cancer? (Please circle) No/Yes If yes, please explain

_____

_____

Have you ever received radiation therapy to the head, neck or chest? (Please circle)

No/Yes If yes, please explain _____

_____

_____

IF YOU HAVE BROUGHT PREVIOUS FILMS OR REPORTS WITH YOU, PLEASE GIVE THEM TO THE RECEPTIONIST BEFORE YOUR EXAM.