THYROID ULTRASOUND

PATIENT NAME: ______________________________

REFERRING PHYSICIAN: ______________________________

REASON FOR EXAMINATION: ______________________________

DO YOU CURRENTLY OR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

_____ NECK PAIN

_____ STIFF NECK

_____ DIFFICULTY SWALLOWING

_____ FEVER

_____ HEADACHE

_____ DIZZINESS

_____ TIREDNESS

_____ WEIGHT LOSS

_____ WEIGHT GAIN

_____ VISUAL DISTURBANCE

_____ HYPOTHYROIDISM

_____ HYPERTHYROIDISM

_____ ABNORMAL THYROID BLOOD TEST

_____ KNOWN THYROID NODULE

_____ ENLARGED THYROID GLAND

PATIENT QUESTIONNAIRE