



UNIT NUMBER:  
PT. NAME:  
DOB:

REFERRING MD:  
ATTENDING MD:  
DATE OF SERVICE:

1. Why are you here today? What are your symptoms or problems?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you been treated for this problem before?  No  Yes If yes, date of last treatment? \_\_\_\_\_

Where were you treated?  NewYork-Presbyterian/Weill Cornell  NewYork-Presbyterian/Columbia  Other

3. Do you have any other health problems?  No  Yes If yes, please describe below:

\_\_\_\_\_  
\_\_\_\_\_

4. What medicines do you take regularly? Include over-the-counter medicines, like aspirin, Tylenol, etc.

\_\_\_\_\_  
\_\_\_\_\_

5. Have you ever been exposed to x-rays or other types of radiation?  No  Yes

If yes, for what condition(s) were you exposed?  Acne or skin problem  Dental x-rays  Enlarged thymus

Tonsil or adenoid problem  Other \_\_\_\_\_

6. Have you ever been treated for thyroid problems?  No  Yes If yes, please describe problem:

\_\_\_\_\_  
\_\_\_\_\_

7. Have you ever been treated for a growth or tumor in your thyroid gland?  No  Yes

If yes, was it cancer?  No  Yes

What type of treatment did you receive for this growth? (check all that apply)

Iodine-<sup>131</sup>  Surgery  Other \_\_\_\_\_ Date of treatment \_\_\_\_\_

Have you ever taken thyroid hormone replacement?  No  Yes If yes, what dose? \_\_\_\_\_

Have you ever taken anti-thyroid hormone medications?  No  Yes If yes, what dose? \_\_\_\_\_

8. Have you ever been treated for any of the following endocrine problems? (check all that apply)

Adrenal tumor  No  Yes Pituitary tumor  No  Yes

Cushing's disease  No  Yes Zollinger Ellison syndrome  No  Yes

Hyperparathyroidism  No  Yes Multiple Endocrine Neoplasia (MEN)  No  Yes

Diabetes  No  Yes

9. Has anyone in your family ever been treated for one of these conditions? (check all that apply)

Adrenal tumor  No  Yes Pituitary tumor  No  Yes

Cushing's disease  No  Yes Zollinger Ellison syndrome  No  Yes

Hyperparathyroidism  No  Yes Multiple Endocrine Neoplasia (MEN)  No  Yes

Diabetes  No  Yes Thyroid tumor  No  Yes

If you answered "yes" to any condition in question 9, which family member(s) have been treated? (Check all that apply.)

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Mother      | <input type="checkbox"/> Father      |
| <input type="checkbox"/> Sister      | <input type="checkbox"/> Brother     |
| <input type="checkbox"/> Daughter    | <input type="checkbox"/> Son         |
| <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Aunt        | <input type="checkbox"/> Uncle       |
| <input type="checkbox"/> Cousin      | <input type="checkbox"/> In-law      |
| <input type="checkbox"/> Other       |                                      |
-