NATIONAL
BREAST CENTER
David C. Weintritt, MD, FACS
Tammy Smith RN MSN, FNP-C

Name: _____ DOB: _____

Thyroid Patient Registration Form

Name: _____ Referring Physician: _____

Reason for visit: _____

Date of last thyroid ultrasound: _____ Which facility?: _____

Any previous thyroid surgery?: _____ Date: _____

Any previous thyroid biopsies or aspirations?: _____ Date: _____

Biopsy or aspiration results?: _____

Have you ever had I-131 radiation treatments(s)?: _____ Date: _____

Have you ever had Antithyroid medication (propylthiouracil, methimazole)?: _____ Date: _____

Have you ever been diagnosed with any of the following?:

Condition	Date	Treatment
Hypothyroidism		
Hyperthyroidism		
Thyroiditis		
Graves Disease		
Hashimoto's Disease		
Thyroid nodules		
Thyroid Cancer (Please indicate type)		

Are you having any difficulty swallowing or breathing? _____

Have you experienced any voice changes? _____

Have you ever been diagnosed with any of the following problems?

- Asthma, COPD Please explain _____
- Kidney disease, Please explain _____
- Thyroid disease, Please explain _____
- Diabetes, Please explain _____
- Hypertension, Please explain _____
- Stroke, Please explain _____
- HIV/AIDS, Please explain _____
- Cancer, Please explain _____

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- Please list any first or second-degree relatives that have had ***breast, ovarian, colon, or pancreatic cancer***, ***thyroid*** and their age at diagnosis:

Relationship to you?	***Mother's or Father's side***	***Type of cancer?***	***Age at diagnosis***

Do you currently smoke? _____ How many cigarettes per day? _____ For how many years?_____

Are you a former smoker? _____ How many cigarettes per day? _____ For how many years? _____

Do you use caffeine? _____ What kind and how much? _____

Alcohol Intake? None Occasional Moderate Heavy Illicit drug use? _____

Past Surgical History: Please check if no prior surgeries ____

List all prior surgeries and the year they were performed

1. _____ Year? _____
2. _____ Year? _____
3. _____ Year? _____
4. _____ Year? _____
5. _____ Year? _____

Current Medications: Please check if no current medications ____

1. _____ Dose? _____
2. _____ Dose? _____
3. _____ Dose? _____
4. _____ Dose? _____
5. _____ Dose? _____
6. _____ Dose? _____

Allergies: Please check if no current allergies ____

1. Medication _____Severity?_____Reaction? _____
2. Medication _____Severity?_____Reaction? _____
3. Medication _____Severity?_____Reaction? _____
4. Medication _____Severity?_____Reaction? _____
5. Other (latex, food) _____Severity?_____Reaction? _____

Pharmacy:_____

Height:_____ Weight:_____