SUMMIT MEDICAL GROUP

Parathyroid Questionnaire

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: _____ Ordering Provider**:** _____

Reason for today's exam: _____

1. Do you have renal (kidney) disease? ☐ YES ☐ NO
   If yes, how many years? _____
2. Do you have high calcium? ☐ YES ☐ NO
3. Do you have a known parathyroid tumor? ☐ YES ☐ NO
4. Do you have problems with your thyroid? ☐ YES ☐ NO
   If yes, please describe? _____
5. Have you had a CT Scan or x-ray procedure with IV Contrast? ☐ YES ☐ NO
   If yes, scan can be performed 4-6 weeks after that appointment
6. Are you taking Amiodarone? ☐ YES ☐ NO
   If yes, medication should be discontinued 3 months before the appointment
7. Have you had recent bloodwork (calcium & PTH) completed? ☐ YES ☐ NO
   If yes, when and where? _____ Calcium Level: _____
8. Have you had an Ultrasound of your neck? ☐ YES ☐ NO
   If yes, when and where? _____
9. Have you had other tests done for your high calcium or neck? ☐ YES ☐ NO
   If yes, when and where? _____
10. Have you had neck surgery? ☐ YES ☐ NO
    If yes, when and where? _____

Signature

I have answered all the above questions to the best of my ability.

_____ _____

Patient Signature (or person authorized to sign for Patient) Date

_____

Relationship to Patient if signing for Patient

_____ _____

Interpreter Signature (or ID# if using service), as applicable Date