DIABETES ASSOCIATES MEDICAL GROUP-
THYROID DISEASE QUESTIONNAIRE

PATIENT NAME: **DOB:**

SYMPTOMS-Describe and circle the correct answer

Please circle any recent symptoms: hair loss, loss of eye lashes, loss of eye brow.
Please circle symptoms: leg rash, dry skin, loss of skin pigmentation
Do you have chronic constipation----------yes/no?
Any excessive daytime sleepiness---------yes/no?
Do you suffer from depression----------yes/no?
Any memory problems or difficulty thinking or concentrating----------yes/no?
Are your nails brittle----------yes/no?
Any cold intolerance or always feeling cold----------yes/no?
Any unintended weight gain--yes/no How many pounds (lb) ---in how many months---
Any unintended weight loss--yes/no How many pounds (lb) ---in how many months----
Do you have frequent stools----------yes/no?
Any heat intolerance or always feeling hot----------yes/no?
Any excessive sweating----------yes/no?
Any heart palpitations or racy heart beat----------yes/no?
Any tremors or shakes----------yes/no?
Any difficulty sleeping or insomnia----------yes/no
Do you suffer from anxiety----------yes/no?
Any history of sudden paralysis and inability to get up----------yes/no?
Please circle symptoms: double vision, eye irritation, eyes pressure, bulging of the eyes.
Any increased appetite----------yes/no?
Any unexplained fatigue----------yes/no?
Any history of any type of heart disease----------yes/no?
Any recent upper respiratory tract infection----------yes/no?
Any pain in lower front part of the neck--yes/no?
Any recent jaw pain----------yes/no?
Any recent ear pain----------yes/no?
Any swelling in the lower front part of the neck----yes/no?
Do you have a history of thyroid lump---yes/no?
Is the thyroid lump smaller----yes/no?
Is the thyroid lump bigger-----yes/no?
Any choking sensation----------yes/no?
Any difficulty swallowing----------yes/no?
Any hoarse voice or change of voice----------yes/no?
Ever treated with X-rays for acne----------yes/no?
Ever treated with radioactive iodine----------yes/no?
Ever received Iodine contrast (dye) for a CT scan in the past 3-4 months----------yes/no?
Have you been exposed to nuclear fallout----------yes/no?
Any previous thyroid surgery----------yes/no?
Do you have a craving to eat salt----------yes/no?
Do you have increased natural tendency for skin sun tanning----------yes/no?

PATIENT NAME: DOB:

Any history of adrenal disease----------yes/no?

Have you taken “steroids” such as hydrocortisone or prednisone recently for longer than 3 weeks--yes/no?

Please circle any symptoms that you experience: irregular menses, heavier menses, lighter menses, less frequent menses, more frequent menses----------

Any history of miscarriages----------yes/no?

What year was your last pregnancy (for females) ----------

If currently pregnant do you have excessive vomiting or morning sickness---------yes/no?

Any infertility or difficulty having a child----------yes/no?

Any decrease in libido----------yes/no?

Do you take Levothyroxine on an empty stomach in the morning----------yes/no?

If you take iron/calcium do you take Levothyroxine 4 hours or more before--------yes/no?

Are you allergic to food color additives such as yellow dye----------yes/no?

Any family history of thyroid disease----------yes/no?

Any family history of thyroid cancer----------yes/no?

Please see the section on the website for medication list and fill out the form.