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# Thyroid Disease Questionnaire

Patient Name/DOB: _____ Date: _____

## Thyroid History

Do you have a **family** history of thyroid disease? ❒ Yes ❒ No

Do you have a **family** history of thyroid cancer? ❒ Yes ❒ No

Do you have a history of sudden paralysis with the inability to get up? ❒ Yes ❒ No

Have you had recent upper respiratory tract infection? ❒ Yes ❒ No

Do you have any of the following? ❒ Yes ❒ No

| | | | |
|---|---|---|---|
| ❒ Leg Rash | ❒ Loss of Skin Pigmentation | ❒ Chronic Constipation | ❒ Dry Skin |
| ❒ Depression | ❒ Excessive Daytime Sleepiness | ❒ Memory Problems | ❒ Brittle Nails |
| ❒ Heat Intolerance | ❒ Cold Intolerance | ❒ Difficulty Concentrating | ❒ Frequent Stools |
| ❒ Excessive Sweating | ❒ Heart Palpitations | ❒ Tremors/Shakiness | ❒ Insomnia |
| ❒ Difficulty Sleeping | ❒ Anxiety | ❒ Unexplained Fatigue | ❒ Increased Appetite |
| ❒Ear Pain | ❒ Lower Front Neck Swelling | ❒ Lower Front Neck Pain | ❒ Choking Sensation |
| ❒ Difficulty Swallowing | ❒ Decreased Libido | ❒ Hoarse Voice | ❒ Salt Craving |

Have experienced any Hair Loss? ❒ Yes ❒ No If yes, answer below:

❒ Loss of Eye Lashes ❒ Loss of Eye Brows ❒ Loss of Scalp Hair

Have you had any unintended weight *gain*? ❒ Yes ❒ No If yes, answer below:

- How many pounds did you gain & within how many months? _____lbs. within _____ months

Have you had any unintended weight *loss*? ❒ Yes ❒ No If yes, answer below:

- How many pounds did you lose & within how many months? _____lbs. within _____ months

Do you have any of the following eye problems:

❒ Double Vision ❒ Eye Irritation ❒ Eye Pressure ❒Eye Bulging

Do you have history of any of the following:

❒ Heart Disease ❒ Adrenal Disease ❒ Thyroid Surgery ❒ Radioactive Iodine Treatment

Do you have history of thyroid "lumps" nodules? ❒ Yes ❒ No

Have any of the thyroid nodules changed in size? ❒ Yes ❒ No If yes, have they ❒ Grown Bigger or ❒ Grown Smaller

Have you ever been treated with X-Rays for acne? ❒ Yes ❒ No

Have you 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

Does your skin have a natural tendency for tanning? ❒ Yes ❒ No

Have you recently taken steroids (such as hydrocortisone or prednisone) for longer than 3 weeks? ❒ Yes ❒ No

Are you allergic to food coloring additives such as yellow dye? ❒ Yes ❒ No

Are you currently taking Levothyroxine? ❒ Yes ❒ No

If yes, do you take it on an empty stomach in the morning: ❒ Yes ❒ No

If you're taking iron or calcium, do you wait 4+ hours after taking levothyroxine to take the supplements? ❒ Yes ❒ No

| For Females Only |
| --- |
| How would you describe your menstrual cycle:<br>❒ Irregular ❒ Heavy ❒Light ❒ Frequent ❒ infrequent<br>Do you have a history of miscarriages? ❒ Yes ❒ No ❒ N/A<br>Do you have a history of infertility or difficulty having children? ❒ Yes ❒ No ❒ N/A<br>If currently pregnant, do you have excessive vomiting or morning sickness? ❒ Yes ❒ No ❒ N/A<br>What year was your last pregnancy? _____ or ❒ N/A |