Endocrine & Diabetes Center

# QUESTIONAIRE FOR THYROID EVALUATION

Name of your referring physician: _____
Name of your primary care physician: _____
Are you self-referred? ❒Yes ❒ No (If yes, how did you find us) _____

Your age: Gender: Marital Status:
Number of children: Occupation: Ethnicity:

**REASON FOR EVALUATION**
❒ OVERACTIVE THYROID (HYPERTHYROIDISM)
❒ UNDERCATIVE THYROID (HYPOTHYROIDISM)
❒ THYROID NODULE(S)
❒ THYROID ENLARGEMENT (GOITER)
❒ THYROID CANCER

**CHIEF COMPLAINT (Please describe):**

_____

**ONSET OF SYMPTOMS:** _____

**DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?**

- ❒ **HYPOTHYROIDISM (UNDERACTIVE THYROID)** ❒ Yes ❒No
  (If yes, check the following boxes)
  ❒ Fatigue and tiredness ❒ Dry skin ❒ Dry hair ❒ Hair loss ❒ Muscle weakness, ❒ Cold intolerance ❒ Weight gain, ❒ Difficulty in concentration ❒ Constipation ❒ Body ache.

- **HYPERTHYROIDISM (OVERACTIVE THYROID)** ❒ Yes ❒No
  (If yes, check the following boxes
  ❒ Sudden weight loss with good appetite ❒ Rapid heartbeat ❒ Palpitations ❒ Increased appetite ❒ Nervousness; anxiety and irritability ❒ Tremor of hands and fingers ❒ Sweating ❒ Increased sensitivity to heat ❒ More frequent bowel movements ❒ Enlarged thyroid gland ❒ Fatigue ❒ Muscle weakness ❒ Difficulty sleeping ❒ Fine and brittle hair

- ❒ **I HAVE NO SPECIFIC SYMPTOMS RELATED TO THYROID**

**WEIGHT HISTORY:**
❒ Weight loss ❒ Weight gain. How many pounds over what period of time? _____

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**RISK FACTORS FOR THYROID DISORDERS: (Please check all boxes that apply).**
❒ History of goiter ❒ History of thyroid nodule ❒ Previous thyroid dysfunction ❒ History of previous radioactive iodine therapy ❒ Previous radiotherapy ❒ Previous thyroid surgery ❒ Neck pain in the front of the neck**:** ❒ History of other autoimmune disorder ❒ History of taking iodine containing drugs ❒ Recent CT scan with contrast ❒ Family history of thyroid disorder

**RESULTS OF THYROID TESTS:** Please bring the results of all thyroid blood tests.

**THYROID ULTRASOUND AND OR THYROID SCAN:** Please bring a copy of the reports.

**PAST MEDICAL HISTORY:**

**Past medical history:** Please list all medical disorders:

_____

_____

**Past surgical procedures:** Please list all surgical procedures:

_____

_____

_____

**FAMILY HISTORY:**

Father: _____
Mother: _____
Sister: _____
Brother: _____
Others (specify): _____

**SOCIAL HISTORY:**

Alcohol ❒ Yes ❒ No; If yes describe_____
Smoking ❒ Yes ❒ No; If yes describe_____
Recreational drugs ❒ Yes ❒ No; If yes describe_____
Hobbies: _____

**ALLERGIES:** ❒ No known drug allergy.
❒ I am allergic to the following drugs: _____

**MEDICATIONS:** Are you taking any of the following thyroid medications
❒ Levothyroxine products such as Synthroid ❒ Armour or Nature thyroid
❒ Methimazole ❒ Propylthiuracil (PTU)
***PLEASE LIST ALL YOUR MEDICATIONS ON THE MEDICATION SHEET.***

**REVIEW OF SYSTEMS: Please complete the review of systems form.**

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