



**HYPERTHYROIDISM QUESTIONNAIRE**

(IF YOU ARE UNABLE TO ANSWER A QUESTION, PLEASE LEAVE IT BLANK – PLEASE PRINT)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. What symptoms brought you to the doctor which led to the diagnosis of hyperthyroidism?

\_\_\_\_\_

2. How long have you had these symptoms?

\_\_\_\_\_

**MEDICAL SYSTEM REVIEW:**

- 3.  YES  NO Heat intolerance? (you feel hot compared to other people)
- 4.  YES  NO Change in appetite?  increased  decreased
- 5.  YES  NO Weight loss? Approximate amount: \_\_\_\_\_ lbs. during the past \_\_\_\_\_ months.
- 6.  YES  NO Increased sweatiness?
- 7.  YES  NO Persistent fever?
- 8.  YES  NO Increased heart rate?
- 9.  YES  NO Palpitations?
- 10.  YES  NO Feeling of skipped heart beats?
- 11.  YES  NO Chest pain?
- 12.  YES  NO Shortness of breath, difficulty in breathing?
- 13.  YES  NO Fatigue / tiredness?
- 14.  YES  NO Muscle weakness / difficulty in lifting objects or walking stairs?
- 15.  YES  NO Shakey arms / hands?
- 16.  YES  NO Worsening handwriting?
- 17.  YES  NO Nervousness / fidgety?
- 18.  YES  NO Unusually emotional?
- 19.  YES  NO Frank psychosis?
- 20.  YES  NO Irritability?
- 21.  YES  NO Depression?
- 22.  YES  NO Difficulty in sleeping?
- 23.  YES  NO Decreased concentrating ability?
- 24.  YES  NO Eye irritation?
- 25.  YES  NO Eye prominence?  left  right  both duration: \_\_\_\_\_
- 26.  YES  NO Eye pain when looking at bright light?
- 27.  YES  NO Eye wateriness?
- 28.  YES  NO Eye dryness?
- 29.  YES  NO Double vision?
- 30.  YES  NO Hair falling out?
- 31.  YES  NO Hair patchiness?
- 32.  YES  NO Hair change in texture: \_\_\_\_\_ (greasy, dry, etc.)
- 33.  YES  NO Enlarged neck mass: \_\_\_\_\_ When was this first noticed: \_\_\_\_\_
- 34.  YES  NO Swelling of ankles?
- 35.  YES  NO Swelling of legs?
- 36.  YES  NO Brittle nails?
- 37.  YES  NO Light color patchiness of skin?
- 38.  YES  NO Diarrhea?
- 39.  YES  NO Change in frequency of bowl movements?  increase  decrease
- 40.  YES  NO Nausea?
- 41.  YES  NO Vomiting?
- 42.  YES  NO Abdominal pain?
- 43.  YES  NO Increased thirst?
- 44.  YES  NO Increased urination?
- 45.  YES  NO Nighttime urination?

(OVER)

(CONTINUED)

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**MEDICAL SYSTEM REVIEW:**

46. **FEMALE**

- A.  YES  NO
- B.  YES  NO

Change in menses?  
Change in sexual desires?

Describe: \_\_\_\_\_  
Describe: \_\_\_\_\_

47. **MALE**

- A.  YES  NO
- B.  YES  NO

Change in sexual desires?  
Breast development?

Describe: \_\_\_\_\_

**CURRENT MEDICATIONS:**

**medication**

**dosage**

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_
- f. \_\_\_\_\_

please list any additional: \_\_\_\_\_

48.  YES  NO

Allergies? list: \_\_\_\_\_

50. **PREVIOUS THERAPIES FOR THYROID DISEASE:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_