



HYPOTHYROIDISM 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 hypothyroidism?

2. How long have you had these symptoms?

MEDICAL SYSTEM REVIEW:

- 3. YES NO Change in work or school performance? If YES, please explain:

- 4. YES NO Sluggish or drowsy?
- 5. YES NO Slow speech?
- 6. YES NO Emotional change? (i.e.: depression, nervous, etc.) If YES, please explain:

- 7. YES NO Has sleep changed? More naps Requires more sleep Sleep less restful
 Snoring Other: _____
- 8. YES NO Change in skin? Dry Greasy Pale
 Thick Thin Yellowish color Cool
 Warm Puffy White patches Bruises easily
Explain: _____
- 9. YES NO Change in hair? Dry Greasy Brittle Falls out more frequently
- 10. YES NO Change in nails? If YES, please explain: _____
- 11. YES NO Change in hearing? If YES, please explain: _____
- 12. YES NO Change in sight? If YES, please explain: _____

PHARYNX / NECK

- 13. YES NO Hoarse voice?
- 14. YES NO Slurred speech?
- 15. YES NO "Thickened tongue" feeling?
- 16. YES NO Change in neck? Enlarged neck mass Tender neck Pressure feeling in the neck

METABOLISM:

- 17. YES NO Do you often feel cold or desire sweaters or extra bedsheets when others are comfortable?
If YES, please explain: _____
- 18. YES NO Change in appetite? Increased Decreased
- 19. YES NO Change in weight over the last year? If YES, how much: _____
- 20. YES NO Difficulty in losing weight inspite of dieting and / or exercise? If YES, please explain: _____

MUSCULOSKELETAL:

- 21. YES NO Have you noticed an INCREASE in any of the following symptoms?
 Numbness Stiffness Extremity tingling Joint pains
 Increased muscle mass Carpal tunnel syndrome
- 22. YES NO Change in bowel movements? Constipation Diarrhea
- 23. YES NO Chest pain?
- 24. YES NO Difficulty in breathing?
- 25. YES NO Do you feel your heart pounding frequently?

PUBERTAL / SEXUAL:

- 26. Would you consider your puberty: Early Late No problems
- 27. YES NO Have you noticed a breast discharge?
- 28. YES NO Have you noticed a change in sexual desires (libido)? If YES: Increased Decreased

(CONTINUED)

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29. YES NO

MALE ONLY – Have you experienced recent impotence?

30.

FEMALE ONLY:

Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

If there is a recent change in menses, please explain: _____

Have you experienced difficulty in becoming pregnant? YES NO

GROWTH – FOR CHILDREN:

31. YES NO

Noticed a decreased growth rate? If YES, over how long a period of time: _____

32. YES NO

Has there been a delay in new tooth growth?

FAMILY HISTORY:

33. YES NO

Are there other family members who have hypothyroidism, hyperthyroidism, or goiter?

If YES, please describe: _____

34. YES NO

Are there family members with diabetes?

If YES, please describe: _____

35. YES NO

Are there other medical problems that have not been discussed?

36.

Current Medications:

37.

Known allergies: