



THYROID PATIENT CONDITION AND SYMPTOMS SURVEY

Patient Name: _____

Date: _____

Address: _____

Date of Birth: _____

City, State, Zip: _____

Home#: _____

Gender (circle one): **MALE** **FEMALE**

Work#: _____

Primary Care Physician: _____

Referring Physician: _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale.***
- *Our procedures are safe and painless.*

Thyroid Patient Condition Survey

[Please Check All Conditions You Experienced or Been Diagnosed with Medically]

1. Hypothyroidism	YES	NO
2. Hyperthyroidism	YES	NO
3. Grave’s Disease	YES	NO
4. Hashimoto’s Disease	YES	NO
5. Fibrocystic Breast Disease	YES	NO
6. Uterine Fibroids	YES	NO
7. Ovarian Fibroids	YES	NO

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8. Breast Disease	YES	NO
9. ADD	YES	NO
10. Vaginal Infections	YES	NO
11. Peyronie's Disease	YES	NO
12. Migraine Headaches	YES	NO
13. Headaches	YES	NO
14. Fatigue	YES	NO
15. Dupuytren's Contractures	YES	NO
16. Excess Mucous Formation	YES	NO
17. Hemorrhoids	YES	NO
18. Keloids	YES	NO
19. Parotid Diet Stones	YES	NO
20. Sebaceous Cysts	YES	NO

Hypothyroidism Risk/Symptoms Checklist

My risk factors for hypothyroidism include:

- I have a family history of thyroid disease
- I have had my thyroid "monitored" in the past to watch for changes
- I had a previous diagnosis of goiters/nodules
- I currently have a goiter
- I was treated for hypothyroidism in the past
- I had post-partum thyroiditis in the past
- I had a temporary thyroiditis in the past
- I have another autoimmune disease
- I have had a baby in the past nine months

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- I have a history of miscarriage
- I have had part/all of my thyroid removed due to cancer
- I have had part/all of my thyroid removed due to nodules
- I have had part/all of my thyroid removed due to Graves' Disease/hyperthyroidism I have had radioactive iodine due to Graves' Disease/hyperthyroidism
- I have had anti-thyroid drugs due to Graves' Disease/hyperthyroidism

I have the following symptoms of hypothyroidism, as detailed by the Merck Manual, the American Association of Clinical Endocrinologists, and the Thyroid Foundation of America .

- I am gaining weight inappropriately
- I'm unable to lose weight with diet/exercise
- I am constipated, sometimes severely
- I have hypothermia/low body temperature (I feel cold when others feel hot, I need extra sweaters, etc.)
- I feel fatigued, exhausted
- Feeling run down, sluggish, lethargic
- My hair is coarse and dry, breaking, brittle, falling out
- My skin is coarse, dry, scaly, and thick
- I have a hoarse or gravelly voice
- I have puffiness and swelling around the eyes and face
- I have pains, aches in joints, hands and feet
- I have developed carpal-tunnel syndrome, or it's getting worse
- I am having irregular menstrual cycles (longer, or heavier, or more frequent)
- I am having trouble conceiving a baby
- I feel depressed

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- ___ I feel restless
- ___ My moods change easily
- ___ I have feelings of worthlessness
- ___ I have difficulty concentrating
- ___ I have more feelings of sadness
- ___ I seem to be losing interest in normal daily activities
- ___ I'm more forgetful lately

Thyroid Patient Symptom Survey

[Please Check All Symptoms You Experience Even if Occassionally]

- | | | |
|-----------------------------|-----|----|
| 1. Weight Gain | YES | NO |
| 2. Slower Heart Rate | YES | NO |
| 3. Poor Memory | YES | NO |
| 4. Muscle Weakness | YES | NO |
| 5. Menstrual Irregularities | YES | NO |
| 6. Infertility | YES | NO |
| 7. Inability to Concentrate | YES | NO |
| 8. Hoarseness | YES | NO |
| 9. Fatigue | YES | NO |
| 10. Essential Hypertension | YES | NO |
| 11. Dry Skin | YES | NO |
| 12. Depression | YES | NO |
| 13. Cold Intolerance | YES | NO |
| 14. Brittle Nails | YES | NO |
| 15. Cold Hands & Feet | YES | NO |
| 16. Constipation | YES | NO |
| 17. Difficulty Swallowing | YES | NO |
| 18. Elevated Cholesterol | YES | NO |

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19. Eyelid Swelling	YES	NO
20. Hair Loss	YES	NO
21. Hypotension	YES	NO
22. Irritability	YES	NO
23. Muscle Cramps	YES	NO
24. Nervousness	YES	NO
25. Puffy Eyes	YES	NO
26. Throat Pain	YES	NO