Thyroid Intake Questionnaire

Patient name: _____ Date of Birth: _____

Self- referral or referred by: _____

Prior endocrinologist (if any): _____

Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

1) **Circle your diagnosis:** Underactive thyroid ____ Over active thyroid____ Thyroid nodules ____ Thyroid cancer____ Abnormal thyroid tests____
2) **What is your chief concern that you would like addressed today?**
   _____
3) **How was your thyroid condition diagnosed?** _____
4) **When was your thyroid condition diagnosed?** _____
5) **Circle which medication you are currently taking:**
   a. Levothyroxine ____ Synthroid ____ Tirosint ____ Nature throid ____ Cytomel ____ Armour thyroid ____
      Other: _____ Dose: _____
   b. Methimazole ____ Propylthiouracil Dose: _____
   c. None of the above____
6) **Are you taking biotin, hair, skin or nail supplements?** Yes____ or No____
7) **Are you taking "thyroid support" or "adrenal support" meds?** Yes ____ or No____
8) **Have you ever taken any of the medications listed below?** Yes____ or No____
   If yes, please circle:
   Amiodarone ____ Lithium ____ Sunitinib (Sutent)____ Sorafenib (Nexavar), Imatinib (Gleevec) ____ Ipilimumab (Yervoy) ____ Nivolumab (Opdivo) ____ Pembrolizumab (Keytruda) ____
9) **Have you had thyroid surgery in the past?** Yes ____ or No____

   If yes, when and why? _____
10) **History of radiation exposure?** Yes____ or No____, If yes, when? _____
11) **Do you have a history of thyroid conditions in your family?** Is yes, please describe
    _____
12) **When was your last thyroid ultrasound (if applicable)?** _____

Questions only for patients with thyroid nodules (If you do not have this, skip to next section):

1) **Have your nodules been biopsied?** Yes ____ or No____
   If yes, when and what was the result_____
   _____

Questions only for patients taking levothyroxine (If you are not, skip to next section):

1) **Do you take your levothyroxine fasting in the morning with a cup of water?** Yes ____ or No____
2) **Do you wait 1 hour to eat or drink anything else?** Yes ____ or No____
3) **Do you wait 4 hours to take any calcium, multivitamin, iron pills?** Yes____ or No____

Past medical history (please check all that apply):

□ Hypertension
□ High cholesterol
□ Anemia
□ Liver disease
□ Heart disease
□ Kidney stones
□ Fibromyalgia
□ Heart failure
□ Atrial fibrillation
□ Sleep apnea
□ Pituitary tumor
□ Adrenal nodule
□ High calcium
□ Anxiety disorder
□ COPD____emphysema
□ Rheumatoid arthritis
□ Ulcerative colitis____Crohn's
□ Adrenal insufficiency
□ PCOS
□ Low vitamin D
□ Bariatric surgery
□ Cancer
□ Celiac disease
□ Low testosterone
□ Osteoporosis
□ Chronic fatigue
□ Diabetes
□ Other health conditions (please write in): _____

Symptoms (Circle if you have had any in the last 1 month):

Fatigue ____ fever ____ weight gain ____ weight loss____

Vision changes ____ trouble swallowing ____ hoarseness____

Dry skin ____ itchy skin____

Chest pain____ shortness of breath ____ leg swelling ____

palpitations Diarrhea ____ constipation ____frequent ____

bowel movements Irregular periods (only applicable to

females)

Night time urination ____ frequent urination____

Anxiety ____ depression____

Intolerance to cold ____ intolerance to heat____ hair loss____

Hand tremor or shaking____

Pain in your hands or feet ____ joint pain____

None of the above____

If you selected fatigue above, please complete this section:

What time do you go to bed? _____

When do you wake up? _____

How many times do you wake up at night? _____

Do you snore? Yes ____ or No____

Do have pauses in breathing while sleeping? Yes ____ or No____

Do you have morning headaches? Yes ____ or No____

Have you had a sleep study? Yes ____ or No____

Have you been diagnosed with obstructive sleep apnea? Yes ____ or No____

Do you use a CPAP or BiPAP machine at night? Yes ____ or No____