

New Patient Questionnaire - Thyroid

Name _____ Date _____ Primary Care Physician _____

Have you had recent thyroid tests? _____ What were the results? _____

Have you had a thyroid: scan _____ ultrasound _____ or radioactive iodine therapy _____

If yes – where and when? _____

Have you had thyroid surgery? _____ When was it? _____

Have you taken thyroid medication? _____ If yes, when? _____

If currently taking, name of pill _____ Dose _____ Last dose _____

When was your last pregnancy? _____

Please circle if you take any of the following: birth control pills female hormones iron
 iodine drops kelp calcium Questran Cordarone (amiodarone)

Illness/Medical History	Self	Family	Details
Diabetes			
Heart Disease			
Kidney Disease			
Thyroid Disease			
Adrenal Disorder			
Pituitary Disorder			
Stroke			
Cancer			
High Cholesterol			
High Blood Pressure			
Osteoporosis			
Other			

Please list any previous surgeries and their dates. _____

Please list all medications, including over the counter and herbal medications with doses, if known.

Are you allergic to any medications? _____

M.D. Initials:

PLEASE MAKE SURE TO COMPLETE BOTH SIDES OF THIS INFORMATION SHEET.

Social History

Do you smoke or have you smoked in the past? _____

Do you drink alcohol? How much? _____

Review of Systems

Please circle any current symptoms you are experiencing.	
General	fatigue, general weakness, weight loss, weight gain, abnormally thirsty
Head	visual difficulty, double vision, blurred vision, change of voice, painful swallowing, difficulty swallowing
Neck	neck pain, swelling
Heart	chest pain, shortness of breath with exertion, rapid heart beating
Lungs	shortness of breath, cough
Gastrointestinal	abdominal pain/discomfort, nausea, vomiting, diarrhea, constipation
Urinary	frequent daytime urination, nighttime urination, frequent urinary or vaginal infections
Reproductive	difficulty with erections, pregnant, post menopause Date of last menstrual period: _____
Skin	rash, dry skin, moist skin, thin skin, easy bruising
Blood	prolonged bleeding, other blood disorders
Endocrine	intolerance to heat, intolerance to cold
Musculoskeletal	calf cramping, previous foot ulcer, previous fracture, osteoporosis
Neurological	burning/numbness/tingling of feet, tremulousness, jitteriness
Psychological	depression, anxiety

M.D. Initials: