Name:

Date: _____

Thyroid Pre-consultation Questionnaire

To provide you with the best care possible, we request that you provide the following information. Your answer on this form will help the doctor understand your medical conditions better and more promptly leaving more tim to discuss your questions. For NO/YES questions, please supply details about any "yes" answers

Thyroid tests were first done because of: □routine testing □ family history □ neck symptoms □other symptoms

If taking thyroid hormone replacement

When did you start: _____

What medications / doses have you used: _____

_____

Please recount approximate dates of last 2-3(?) thyroid dose changes: _____

_____

You take thyroid pills how long: a) after last food/vitamins:_____b) Before next food/vit's _____

The thyroid sits in the base of the anterior neck (where a neck-tie would be tied). Are you having:

□ Pain in the lower neck NO/ YES _____

□ Changes in voice (volume, hoarseness, etc) NO/ YES _____

□ Difficulty swallowing NO/ YES _____

Is Fatigue a significant issue NO/ YES If yes then please answer:

When did you last feel energetic: _____

You generally go to bed at ?time:_____PM/AM and need about_____min/ hrs to fall asleep

You usually wake #times_____overnight. You get up at_____PM/AM. You Nap: NO/YES

Do you Snore: NO/YES:_____Prior Sleep apnea evaluation: NO/YES: _____

Regarding factors that may indicate a problem that can contribute to thyroid problems did you have :

History of neck radiation therapy: NO/YES: _____

Use of iodine, kelp or "thyroid support" supplements NO/YES: _____

PERSONAL MEDICAL HISTORY (indicate if you have the following with YEAR OF DIAGNOSIS)

Medical Problem	Year of Diagnosis/ Details	Medical Problem	Year of Diagnosis/ Details
□ High Blood Pressure		□ Osteoporosis	
□ High Cholesterol		□ Broken Bone	
□ Heart Attack		□ Liver problems/Hepatitis	
□ Stroke		□ Bleeding Problems	
□ Atrial Fibrillation		□ Intestinal Problems	
□ Celiac Disease		□ Thyroid Problem	
□ Cancer		□ Emphysema/COPD	
□ Depression / Anxiety		□ Asthma	
□ Kidney Disease		□ Smoking	
□ Kidney Stones		□ Alcoholism	

Other Problems: _____

_____

_____

SURGICAL HISTORY (list all procedures and operations with year)

Procedure/Surgery	Year	Procedure/Surgery	Year

WOMEN- Menstrual /Pregnancy history

Age of 1st menstruation:_____ Frequency of periods:_____ Length of period: _____ Menopause age: _____

#of Pregnancies:_____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Other female problems _____

If menopausal, using / used Estrogen / Progesterone treatment: Never / Yes. Details: _____

FAMILY HISTORY	**Age**	**Age of Death**	**Cause of Death and/or Medical Problems**
Mother:			
Father:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			

Current Symptom Review

Rate average energy past week (1=low, 10= high): _____/10

	Symptoms		No Problem	Issue details: circle one N =new, C = chronic. → **Please provide details /changes.**
a)	Fevers/ Sweats	a)		N / C →
b)	Intolerance of cold	b)		N / C →
c)	Intolerance of heat	c)		N / C →
d)	Vision change	d)		N / C →
e)	Sinus or ear symptoms	e)		N / C →
f)	Chest Pains	f)		N / C →
g)	Heart Racing	g)		N / C →
h)	Leg swelling (edema)	h)		N / C →
i)	Shortness of breath	i)		N / C →
j)	Cough	j)		N / C →
k)	Nausea or Vomiting	k)		N / C →
l)	Abdominal Pain	l)		N / C →
m)	Discomfort w/ urination	m)		N / C →
n)	Joint Pains	n)		N / C →
o)	Balance problems / Falls	o)		N / C →
p)	Difficulty with memory	p)		N / C →
q)	Tremor	q)		N / C →
r)	Headaches	r)		N / C →
s)	Skin rash or skin lesions	s)		N / C →
t)	Hair Loss	t)		N / C →
u)	Bleeding / Bruising	u)		N / C →
v)	Allergies	v)		N / C →
w)	Insomnia	w)		N / C →
x)	Anxiety	x)		N / C →
y)	Depression	y)		N / C →
z)	Men:Erectile dysfunction	z)		N / C →

Bowel Movements: Per day _____ OR Per week _____

Urinating at night: none OR # per night _____

Name:

Date:

SOCIAL HISTORY

Tobacco Use: □ Never □ Quit (Year: ____, After using for_____yrs)

□ Current: # packs/day _____ , # of years _____

Alcohol Use: □ Never □ Quit (Year:_____)

□ Drink _#_____ drinks per day / week / month / year (please circle one)

Drug Use: □ Current □ Never □ Quit (Year:_____) What used?:_____

Have you ever used injectable (i.e. IV) recreational drugs □ Yes □ No

Marital Status: □ Married □ Single □ Separated □ Domestic Partner □ Other: _____

□ Widowed- what year? _____

Sexual Activity: Sexually active? □ Yes □ No □ Not Currently

Current partner is □ Male □ Female

Birth control method (if applicable): _____

Retired? Yes / No. Current or Past Occupation: _____

Highest level of school completed:_____

MEDICATION ALLERGIES / INTOLERANCES: □ NONE

Drug	Reaction	Drug	Reaction

CURRENT MEDICATIONS

Drug	Dose (pill size?)	Dose (amount & frequency)
□ Aspirin	□ 81mg □325 mg	□ One tab once daily □ One tab twice daily _