## **Thyroid Intake Questionnaire**

Patient r	name: Date of Birth:
Self- refe	erral or referred by:
Prior end	docrinologist (if any):
	* PLEASE RETURN COMPLETED FORM PRIOR 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?
	When was your thyroid condition diagnosed?
-	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)?
Questio	ns 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
	,,

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): □ COPD/emphysema ☐ Hypertension ☐ Heart failure □ Bariatric surgery ☐ High cholesterol □ Atrial fibrillation □ Rheumatoid arthritis □ Cancer □ Anemia □ Sleep apnea □ Ulcerative colitis/Crohn's □ Celiac disease □ Liver disease □ Pituitary tumor □ Adrenal insufficiency □ Low testosterone ☐ Heart disease □ Adrenal nodule □ PCOS □ Osteoporosis ☐ Kidney stones ☐ High calcium □ Low vitamin D ☐ Chronic fatigue □ Fibromyalgia ☐ Anxiety disorder ☐ Restless leg syndrome □ 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\_\_\_\_\_

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

## 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