Palm Beach Diabetes & Endocrine Specialists, P.A.
Thyroid Questionnaire

Last Name:_____ First Name:_____

Your Age: _____ Sex: _____ Date of Birth:_____ Phone: _____

What is your thyroid condition?

	Overactive		Enlarged thyroid
	Underactive		Thyroid Tumor
	Nodule(s)		Painful

If "other" please describe:

_____

_____

How long have you had a thyroid problem? _____

Did you have a thyroid scan? ☐ Yes ☐ No

If so, when? _____ What did it show? _____

Check all thyroid therapies you have received:

	Propylthiouracil (PTU)		Tapazole
	Radioactive Iodine		Thyroid hormone (Synthroid, Armour, etc.)
	Neck Surgery		Other (explain)

Are you experiencing any of the following?

	Y	N		Y	N		Y	N
Fatigue			Restlessness / nervous			Hair loss		
Feeling cold			Feeling hot			Depression		
Weight gain			Weight loss			Itchy skin		
Constipation			Diarrhea			Menstrual disturbance		
Dry skin			Palpitations			Puffiness around eyes		
Muscle cramps			Itchy eyes			Cough		
Brittle nails			Sweaty			Shortness of breath		
Swelling ankles			Shakiness			Insomnia		

Have you had any pregnancies? ☐ Yes ☐ No When was the last one?_____

Are your menstrual cycles (if applicable) regular? ☐ Yes ☐ No

If "no" are they: ☐ too frequent? ☐ too infrequent? ☐ Irregular?

List any family members with thyroid disease and explain what type of condition they have:

_____

_____

What is the most important question you have regarding your thyroid condition?

_____

_____

_____