BMG | THE ENDOCRINE CLINIC

HYPERTHYROIDISM QUESTIONNAIRE

IF YOU ARE UNABLE TO ANSWER A QUESTION, PLEASE LEAVE IT BLANK – PLEASE PRINT.

Name: ______________________________ Date: ______________

1. What symptoms brought you to the doctor which led to the diagnosis of hyperthyroidism?

____

2. How long have you had these symptoms?

____

MEDICAL SYSTEM REVIEW:

3. ☐ YES ☐ NO Heat intolerance? (you feel hot compared to other people)
4. ☐ YES ☐ NO Change in appetite? ☐ increased ☐ decreased
5. ☐ YES ☐ NO Weight loss? Approximate amount: ________ lbs. during the past ________ months
6. ☐ YES ☐ NO Increased sweatiness?
7. ☐ YES ☐ NO Persistent fever?
8. ☐ YES ☐ NO Increased heart rate?
9. ☐ YES ☐ NO Palpitations?
10. ☐ YES ☐ NO Feeling of skipped heart beats?
11. ☐ YES ☐ NO Chest pain?
12. ☐ YES ☐ NO Shortness of breath, difficulty in breathing?
13. ☐ YES ☐ NO Fatigue / tiredness?
14. ☐ YES ☐ NO Muscle weakness / difficulty in lifting objects or walking stairs?
15. ☐ YES ☐ NO Shakey arms / hands?
16. ☐ YES ☐ NO Worsening handwriting?
17. ☐ YES ☐ NO Nervousness / fidgety?
18. ☐ YES ☐ NO Unusually emotional?
19. ☐ YES ☐ NO Frank psychosis?
20. ☐ YES ☐ NO Irritability?
21. ☐ YES ☐ NO Depression?
22. ☐ YES ☐ NO Difficulty in sleeping?
23. ☐ YES ☐ NO Decreased concentrating ability?
24. ☐ YES ☐ NO Eye irritation?
25. ☐ YES ☐ NO Eye prominence? ☐ Left ☐ Right ☐ Both Duration: ________
26. ☐ YES ☐ NO Eye pain when looking at bright light?
27. ☐ YES ☐ NO Eye wateriness?
28. ☐ YES ☐ NO Eye dryness?
29. ☐ YES ☐ NO Double vision?
30. ☐ YES ☐ NO Hair falling out?
31. ☐ YES ☐ NO Hair patchiness?
32. ☐ YES ☐ NO Hair change in texture: ______________________ (greasy, dry, etc.)
33. ☐ YES ☐ NO Enlarged neck mass: When was this first noticed: ______________
34. ☐ YES ☐ NO Swelling of ankles?
35. ☐ YES ☐ NO Swelling of legs?
36. ☐ YES ☐ NO Brittle nails?
37. ☐ YES ☐ NO Light color patchiness of skin?
38. ☐ YES ☐ NO Diarrhea?
39. ☐ YES ☐ NO Change in frequent of bowel movements? ☐ Increase ☐ Decrease
40. ☐ YES ☐ NO Nausea?
41. ☐ YES ☐ NO Vomiting?
42. ☐ YES ☐ NO Abdominal pain?
43. ☐ YES ☐ NO Increased thirst?
44. ☐ YES ☐ NO Increased urination?
45. ☐ YES ☐ NO Nighttime urination?

BMG | THE ENDOCRINE CLINIC

HYPERTHYROIDISM QUESTIONNAIRE

MEDICAL SYSTEM REVIEW:

46. **FEMALE**

A. ☐ YES ☐ NO Change in menses? Describe: ______________________

B. ☐ YES ☐ NO Change in sexual desires? Describe: ______________________

47. **MALE**

A. ☐ YES ☐ NO Change in sexual desires? Describe: ______________________

B. ☐ YES ☐ NO Breast development?

CURRENT MEDICATIONS: **medication** **dosage**

a. ______________________

b. ______________________

c. ______________________

d. ______________________

e. ______________________

f. ______________________

please list any additional: ______________________

____

____

48. ☐ YES ☐ NO Allergies? List: ______________________

50. PREVIOUS THERAPIES FOR THYROID DISEASE:

____

____

____

____

____