

Thyroid/Parathyroid History Form

Patient Name: _____ Today's Date: _____

1. Reason for today's visit : _____

2. Have you ever experienced any of the following...

- | | |
|--|--|
| <input type="checkbox"/> Decreased energy level or fatigue | <input type="checkbox"/> Shaking, nervousness, jitters, irritability |
| <input type="checkbox"/> Slowed thinking | <input type="checkbox"/> Feeling hot |
| <input type="checkbox"/> Feeling Cold | <input type="checkbox"/> More frequent bowel movements |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Muscle weakness, fatigue |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Dry brittle skin, hair and nails | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Longer or heavier menstrual periods | <input type="checkbox"/> Shorter or lighter menstrual periods |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Rapid or irregular heartbeat |
| <input type="checkbox"/> Frequent Urination | |

3. Any history of thyroid nodules? Yes No

4. Have you had any recent blood work? Yes No

a. If yes, please specify when and where? _____

5. Any recent neck images? Yes No

a. If yes, please specify when and where? _____

6. Any family history of thyroid or parathyroid disease? Yes No

7. Any history of kidney stones, bone or joint pain? Yes No

8. Any history of stomach pain, pancreatitis or ulcer problems? Yes No