Thyroid / Parathyroid History Form

Patient Name:_____ Today's Date: _____

1. Reason for today's visit : _____
2. Have you ever experienced any of the following…

☐ Decreased energy level or fatigue	☐ Shaking, nervousness, jitters, irritability
☐ Slowed thinking	☐ Feeling hot
☐ Feeling Cold	☐ More frequent bowel movements
☐ Constipation	☐ Muscle weakness, fatigue
☐ Muscle pain	☐ Unintentional weight loss
☐ Dry brittle skin, hair and nails	☐ Hair Loss
☐ Longer or heavier menstrual periods	☐ Shorter or lighter menstrual periods
☐ Weight gain	☐ Rapid or irregular heartbeat
☐ 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