BMG | THE ENDOCRINE CLINIC

# *HYPOTHYROIDISM 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 hypothyroidism?

_____

2. How long have you had these symptoms?

_____

**MEDICAL SYSTEM REVIEW:**

3. ☐ YES ☐ NO Change in work or school performance? If YES, please explain:

_____

4. ☐ YES ☐ NO Sluggish or drowsy?
5. ☐ YES ☐ NO Slow speech?
6. ☐ YES ☐ NO Emotional change? (i.e.: depression, nervous, etc.) If YES, please explain:

_____

7. ☐ YES ☐ NO Has sleep changed? ☐ More naps ☐ Requires more sleep ☐ Sleep less restful ☐ Snoring ☐ Other: _____
8. ☐ YES ☐ NO Change in skin? ☐ Dry ☐ Greasy ☐ Pale ☐ Thick ☐ Thin ☐ Yellowish color ☐ Cool ☐ Warm ☐ Puffy ☐ White patches ☐ Bruises easily
   Explain: _____
9. ☐ YES ☐ NO Change in hair? ☐ Dry ☐ Greasy ☐ Brittle ☐ Falls out more frequently
10. ☐ YES ☐ NO Change in nails? If YES, please explain: _____
11. ☐ YES ☐ NO Change in hearing? If YES, please explain: _____
12. ☐ YES ☐ NO Change in sight? If YES, please explain: _____

**PHARYNX / NECK**

13. ☐ YES ☐ NO Hoarse voice?
14. ☐ YES ☐ NO Slurred speech?
15. ☐ YES ☐ NO "Thickened tongue" feeling?
16. ☐ YES ☐ NO Change in neck? ☐ Enlarged neck mass ☐ Tender neck ☐ Pressure feeling in the neck

**METABOLISM**

17. ☐ YES ☐ NO Do you often feel cold or desire sweaters or extra bedsheets when others are comfortable?
    If YES, please explain: _____
18. ☐ YES ☐ NO Change in appetite? ☐ Increased ☐ Decreased
19. ☐ YES ☐ NO Change in weight over the last year? If YES, how much: _____
20. ☐ YES ☐ NO Difficulty in losing weight in spite of dieting and/or exercise? If YES, please explain: _____

_____

**MUSCULOSKELETAL:**

21. ☐ YES ☐ NO Have you noticed an INCREASE in any of the following symptoms?
    ☐ Numbness ☐ Stiffness ☐ Extremity tingling ☐ Joint pains
    ☐ Increased muscle mass ☐ Carpal tunnel syndrome
22. ☐ YES ☐ NO Change in bowel movements? ☐ Constipation ☐ Diarrhea
23. ☐ YES ☐ NO Chest pain?
24. ☐ YES ☐ NO Difficult in breathing?
25. ☐ YES ☐ NO Do you feel you heart pounding frequently?

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**PUBERTAL / SEXUAL:**

26. Would you consider your puberty: ☐ Early ☐ Late ☐ No problems

27. ☐ YES ☐ NO Have you noticed a breast discharge?

28. ☐ YES ☐ NO Have you noticed a change in sexual desires (libido)? If YES: ☐ Increased ☐ Decreased

29. ☐ YES ☐ NO **MALE ONLY –** Have you experienced recent impotence?

30. ☐ YES ☐ NO **FEMALE ONLY:**
Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____
If there is a recent change in menses, please explain: _____
Have you experienced difficulty in becoming pregnant? ☐ YES ☐ NO

**GROWTH – FOR CHILDREN:**

31. ☐ YES ☐ NO Noticed a decreased growth rate? If YES, over how long a period of time: _____

32. ☐ YES ☐ NO Has there been a delay in new tooth growth?

**FAMILY HISTORY:**

33. ☐ YES ☐ NO Are there other family members who have hypothyroidism, hyperthyroidism, or goiter?
If YES, please describe: _____

34. ☐ YES ☐ NO Are there family members with diabetes?
If YES, please describe: _____

35. ☐ YES ☐ NO Are there other medical problems that have not been discussed?

36. Current Medications:

37. Known Allergies: