The Hospital of Central Connecticut

Welcome to the Center for Metabolic Health

THYROID QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

Questions and goals for this visit:

_____

Have you been told you have a thyroid disorder? (i.e. underactive thyroid/hypothyroidism, overactive thyroid/Graves' disease, thyroid cancer, thyroid nodules, goiter)

_____

Have you ever had your thyroid ablated? Y or N If yes, what year: _____

Have you ever received neck radiation? Y or N

Do you take any supplements or medications from your home country for your thyroid? Y or N

If yes, please list them:_____

Have you ever been prescribed lithium, amiodarone, or interferon alpha? Y or N

Do you take thyroid medication? If yes, which medication (levothyroxine,synthroid, armour):_____

Do you ever forget to take your medication? Y or N

Do you take biotin (supplement sometimes used to strengthen skin, hair, and nails)? Y or N

Have you ever had a thyroid ultrasound? If yes, when and where:_____

Have you ever had an uptake and scan? If yes, when and where: _____

Family history: Do you have any family history of thyroid disease?

- Overactive thyroid
- Underactive thyroid
- Thyroid removal (either surgically or through radioactive iodine)
- Thyroid Cancer

Do any of your blood relatives autoimmune disease (celiacs, vitiligo, multiple sclerosis, rheumatoid arthritis, type 1 diabetes, etc)? _____

Any other health information you would like to tell us regarding your thyroid?

_____
_____
_____
_____
_____
_____
_____
_____