Diabetes & Endocrine
SPECIALISTS OF SOUTHWEST OHIO

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NEW PATIENT QUESTIONNAIRE -- THYROID

Please help us by filling out this form before your visit with the doctor. If you need help, please call (937)395-9966 or notify the front desk or medical assistant when you come to your appointment.

NAME _____ **Date of Birth**____/____/____ **Today's Date**____/____/____
First Last

When were you diagnosed with thyroid disease?	Year _____ Age _____
What was your approximate weight at that time?	_____ lbs
Have you been hospitalized for thyroid condition? ☐No ☐Yes: When and where?	_____/_____/_____ _____
Do you have any complications related to thyroid disease? (circle)	eye skin weight mood other
Have you had an thyroid ultrasound to evaluate your thyroid disease? ☐ No ☐Yes: When and where?	_____/_____/_____ _____
Have you ever had a biopsy of your thyroid? ☐ No ☐Yes: When and where?	_____/_____/_____ _____
Have you had surgery on your thyroid or anterior (front part) of your neck?	☐ No ☐ Yes, date : _____/_____/_____

CHECK THYROID CONDITIONS/ THYROID RISK FACTORS:

	Current	Past	Notes/Details:
☐ Goiter (enlarged thyroid)	☐	☐	
☐ Thyroid nodule(s)	☐	☐	
☐ Thyroid Cancer	☐	☐	
☐ Papillary thyroid cancer ☐ Follicular thyroid cancer ☐ Medullary thyroid cancer			
☐ Hyperthyroidism (overactive thyroid)	☐	☐	
☐Graves' Disease ☐Post partum thyroiditis ☐Subacute thyroiditis ☐Iodine induced thyroiditis ☐Toxic multinodular goiter			
☐ Hypothyroidism (underactive thyroid)	☐	☐	
☐ Hashimoto's thyroiditis ☐ Post-surgical hypothyroidism ☐ Post-iodine ablation hypothyroidism ☐ Central hypothyroidism due to pituitary disease			
☐ History of radioactive exposure/ neck radiation	☐	☐	
☐ Family history of hypothyroidism (underactive thyroid)			
☐ Family history of hyperthyroidism (overactive thyroid)			
☐ Family history of autoimmune conditions			
☐ Family history of thyroid cancer			
☐ Other thyroid concern			
☐ Planning for pregnancy? ☐ No ☐ Yes: when?			

Current Medications **PLEASE BRING A LIST OF YOUR MEDICATIONS TO *ALL* APPOINTMENTS.** REMEMBER TO INCLUDE INJECTED, INHALED MEDICATIONS, DIABETIC SUPPLIES, VITAMINS, SUPPLEMENTS AND MEDICATIONS PURCHASED OVER-THE-COUNTER.

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General Medical History (check all that apply)

☐ Anemia	☐ Emphysema or COPD	☐ High cholesterol	☐ Frequent UTIs
☐ Asthma	☐ GERD/ Reflux	☐ Obesity	☐ Fibromyalgia
☐ Arthritis	☐ Glaucoma	☐ Osteoporosis	☐ Intestinal bleeding
☐ Cancer or tumors	☐ HIV/AIDS	☐ Seizures	☐ Liver disease
☐ Cataract(s)	☐ High blood pressure	☐ Sleep Apnea	☐ Gall Bladder disease
☐ CHF/ Heart failure	☐ Kidney disease	☐ Stroke	☐ Kidney stones
☐ Blood clots	☐ Heart attack	☐ Hypothyroidism	☐ Gastroparesis
☐ Diabetes	☐ Heart disease	☐ Hyperthyroidism	☐ Pancreatitis
☐ Depression		☐ Stomach ulcers	☐ Gout

Please write other health problems not listed above.

_____

_____

Hospitalizations and Operations

Medication Allergies List any medication allergies and the type of reaction that occurs.

_____

_____

Immunizations List date completed**.**

Tetanus booster	/ /	Pneumovax (pneumonia)	/ /	Influenza (flu)	/ /
Hepatitis B	/ /	Shingles	/ /		

Family History (check, indicate who)

Diabetes ☐No ☐Yes, who:_____

High blood pressure ☐No ☐Yes, who:_____

High cholesterol ☐No ☐Yes, who:_____

Heart Disease ☐No ☐Yes, who:_____

Other Cancer ☐No ☐Yes, who, what type? _____

Osteoporosis ☐No ☐Yes, who:_____

Other_____

Social History

Occupation	**Highest level of education**	**Home Life:**
If retired or disabled, occupation when working?		☐**single** ☐**married** ☐**divorced** ☐**widowed** **Live with:** _____

Substances used		**What and How much?**
Alcohol	☐No ☐Yes	
Tobacco	☐No ☐Yes	
Addictive drugs	☐No ☐Yes	

Do you exercise?	**How Often/What Activities?**	**What Limits Your Physical Activity?**
☐No ☐Yes		

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NAME _____ **Date of Birth**_____

Review of Systems (check symptoms you have had recently)

General
- ☐ Activity change
- ☐ Appetite change
- ☐ Sweating
- ☐ Fatigue
- ☐ Unexpected weight change

Head/Ear/Nose/Throat
- ☐ Sinus congestion
- ☐ Dental problems
- ☐ Hearing loss
- ☐ Trouble swallowing
- ☐ Voice change

Eyes
- ☐ Light sensitivity
- ☐ Vision changes

Breathing and Lungs
- ☐ Snoring /Apnea
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Heart
- ☐ Chest pain/tightness
- ☐ Leg swelling
- ☐ Palpitations

Stomach/Intestinal
- ☐ Abdominal bloating
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Gland/Hormone
- ☐ Increased thirst
- ☐ Increased urination

Genitourinary
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urgency
- ☐ Decreased urination

Muscle and Skeletal
- ☐ Joint pains
- ☐ Back pain
- ☐ Walking difficulties
- ☐ Joint swelling
- ☐ Muscle aches

Skin
- ☐ Rash
- ☐ Wound/sores/ulcers

Neurological
- ☐ Dizziness or lightheaded
- ☐ Headaches
- ☐ Numbness or tingling pain
- ☐ Passing out/losing consciousness
- ☐ Weakness

Hematologic
- ☐ Lymph gland swelling
- ☐ Easy bruising

Psychiatric
- ☐ Confusion
- ☐ Depression
- ☐ Nervousness/anxiety
- ☐ Sleep disturbance

Medications you need refilled:

_____

_____

_____

_____

Labs you need ordered or have questions about:

_____

_____

_____

_____