**Hypothyroid Risk Questionnaire**

Name:Click here to enter text. DOB:Click here to enter text. Date:Click here to enter text. Email:Click here to enter text.

This questionnaire assesses low thyroid function. For overactive thyroid see Hyperthyroid Risk Questionnaire. The more items checked below the greater the possibility you have thyroid dysfunction. Certain symptoms/associations have a higher likelihood than others.

Please mark the box of any that apply. Indicate the severity of each symptom you are experiencing currently by typing a 1 – 5 (1=mild/5=severe) in the middle of the red line ( \_\_ ). Some questions may not sound as if they are requesting severity information or you may be unsure of the severity. In these situations please enter your best guess. If the symptom is current, simply place a number in the provided space. If it is a symptom that you have had in the past, please indicate severity & type the word “past” in the space.

When you have completed the form, save it and email it back to [SPHW@stpetehw.com](mailto:SPHW@stpetehw.com) or call our office at 727-202-6807 to make an appointment.

**Risk Factors**

I have a family history of thyroid disease

I have been treated for thyroid disease

I have had thyroid surgery

I have taken anti-thyroid medication

I have taken thyroid medication

I have been monitored for my thyroid

I’ve had temporary thyroiditis

I have/had a goiter / thyroid nodule

I have another autoimmune disease

**Symptoms/Associations**

\_\_ I am gaining weight inappropriately

\_\_ I'm unable to lose weight

\_\_ I have poor circulation hands or feet

\_\_ I get cold hands and feet

\_\_ I feel cold much of the time

\_\_ I feel fatigued, exhausted

\_\_ Feeling run down, sluggish, lethargic

\_\_ I feel weak

\_\_ I have thinned and lost eyelashes

\_\_ I lost the outer portion of my eye brows

\_\_ My hair is coarse, dry, breaking, brittle

\_\_ I am losing my hair

\_\_ My skin is coarse, dry, scaly, and thick

\_\_ My nails are brittle

\_\_ My ears itch

\_\_ I have excess ear wax

\_\_ I have ringing in my ears

\_\_ I get dizzy

\_\_ My eyes feel dry or gritty

\_\_ I get blurry vision that clears with blinking

\_\_ My eyelids droop

\_\_ My eyes sometimes close on their own

\_\_ I have a hoarse or gravelly voice

\_\_ I have facial puffiness and swelling

\_\_ I have aches in joints, hands and feet

\_\_ I have carpal-tunnel syndrome

\_\_ I get injuries from repetitive exercise

\_\_ My hands or feet tingle / get numb

\_\_ I get muscle cramps

\_\_ I am stiff in the morning

\_\_ My memory is worse

\_\_ I have difficulty concentrating

\_\_ My thinking & speech have slowed

\_\_ My mood changes easily

\_\_ I feel depressed

\_\_ I have feelings of worthlessness

\_\_ I feel often sad

\_\_ I am losing interest

\_\_ I feel anxious / restless

\_\_ I feel agitated / irritable

\_\_ My reflexes are slow or absent

\_\_ I have restless legs

\_\_ I have trouble sleeping

\_\_ I wake to go to the bathroom

\_\_ I snore

\_\_ I get frequent headaches

\_\_ I get frequent infections

\_\_ Infections last too long

\_\_ I have asthma

\_\_ I have allergies

\_\_ I feel short of breath

\_\_ I yawn often

\_\_ I have odd feelings in my neck/throat

\_\_ I have chest tightness

\_\_ I have a history of heart disease

\_\_ I have high/low blood pressure

\_\_ I have blood pressure irregularities

\_\_ I have slow pulse / bradycardia

\_\_ I have palpitation

\_\_ I have high cholesterol / lipids

\_\_ I have diabetes / prediabetes

\_\_ I have decreased interest in sex

\_\_ I am less sexually aroused with sex

\_\_ It takes me a long time to orgasm

\_\_ I cannot achieve orgasm

\_\_ We can’t get pregnant

\_\_ I have / had tender breasts

**Women**

\_\_ I’ve had a miscarriage

\_\_ I’ve had a baby in the past 9 months

\_\_ I’ve had postpartum thyroiditis

\_\_ I do / have use/d birth control pills

\_\_ I have / had endometriosis

\_\_ I have / had cystic breasts / ovaries

\_\_ I have a family history of breast cancer

\_\_ I have / had breast cancer

\_\_ I have PMS

\_\_ I have severe menstrual cramps

\_\_ I am having irregular menstrual cycles (longer, heavier or more frequent)

**Men**

\_\_ I have erectile dysfunction

\_\_ I have delayed or absent ejaculation

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