

THYROID DISORDERS QUESTIONNAIRE

QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	Fist Name	Initial
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Date of Birth	MM / DD / YY
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2. DIAGNOSIS

Please provide details about when the condition was diagnosed:

Date of Diagnosis	MM / DD / YY	Diagnosis:	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Hypothyroidism
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Cause:	<input type="checkbox"/> Serious diseases	<input type="checkbox"/> Simple Goiter	<input type="checkbox"/> Nodular Goiter	<input type="checkbox"/> Thyroiditis	<input type="checkbox"/> Thyroiditis Hasimoto
	<input type="checkbox"/> Medical	<input type="checkbox"/> Iodine deficiency	<input type="checkbox"/> Thyroid nodule	<input type="checkbox"/> Thyroid malignancy	
	<input type="checkbox"/> Congenital	<input type="checkbox"/> Pituitary adenoma	<input type="checkbox"/> Other (specify):		

Is the patient under treatment? Yes No If "Yes", please provide details.

Has radioactive iodine been administered? Yes No

Has the patient undergoing any of the following procedures?
 Biopsy Yes No Total thyroidectomy Yes No Partial thyroidectomy Yes No
 If you answer yes to any of the above, please include the pathology report

Please provide the following information:
 Blood test values no longer than 6 months (Please include the lab report):
 TSH T4 Antithyroid peroxidase antibody
 Thyroid ultrasound result (no longer than 1 year). Omit only in case of total thyroidectomy

Has the patient undergone thyroid gamagrama? Yes No If "Yes", please provide details.

If you have had thyroid cancer, please attach complete medical record

Are there other diseases, complications, factors or symptoms that have not been mentioned before? Yes No
 If you answer yes to any of the above, please include the pathology report

3. TREATING PHYSICIAN'S INFORMATION

Name	Last	Fist Name	Initial
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Address	
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telephone	Fax
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Email	
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4. SIGNATURE

Physician's signature		Date	MM / DD / YY
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Physician's signature		Date	MM / DD / YY
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