

Thyroid Evaluation Survey

Name: _____ Sex: _____ Date: _____

Address: _____

Please score the following questions with "0" being the least or not at all and "5" being the highest score.

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|--|-------------|
| 1. Do you feel exhausted from morning to night | 0 1 2 3 4 5 |
| 2. Do you have trouble getting up in the morning | 0 1 2 3 4 5 |
| 3. Are you stiff in the morning? | 0 1 2 3 4 5 |
| 4. Do you have dry skin, brittle hair or nails? | 0 1 2 3 4 5 |
| 5. Do you have cold hands and feet? | 0 1 2 3 4 5 |
| 6. Is your short-term memory failing? | 0 1 2 3 4 5 |
| 7. Do you go to pieces easily or dislike working under pressure? | 0 1 2 3 4 5 |
| 8. Do you have difficulty losing weight no matter what diet or exercise plan you follow? | 0 1 2 3 4 5 |
| 9. Are you depressed? | 0 1 2 3 4 5 |
| 10. Are you constipated? | 0 1 2 3 4 5 |
| 11. Do your muscles feel weak as if they can't generate energy? | 0 1 2 3 4 5 |
| 12. Is your cholesterol over 200? | Y / N |
| 13. Do you have PMS or menstrual difficulties? | Y / N |
| 14. Have you had trouble conceiving a child? | Y / N |
| 15. Is your first morning under arm body temperature less than 97.8 degrees fahrenheit? | Y / N |
| 16. Do you currently use some form of thyroid supplement? | Y / N |
| 17. Do you have a low sex drive? | Y / N |