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.

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
    a. Do you have PMS or menstrual difficulties? Y / N
13. Have you had trouble conceiving a child? Y / N
14. Is your first morning under arm body temperature less than 97.8 degrees fahrenheit? Y / N
    a. Do you currently use some form of thyroid supplement? Y / N
15. Do you have a low sex drive? Y / N

16. Do you currently use some form of thyroid supplement? Y / N

17. Do you have a low sex drive? Y / N