



Hypothyroidism New Patient Application and Case History

Name _____ Age _____ Sex: M F DOB _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____ e-mail: _____
May we leave a voice mail? Y N Height _____ Weight: _____ How Did You Hear About Us? _____
Employer _____ Occupation _____ Length of Employment _____ SSN _____-_____-_____

Present Complaints

- Main Problem(s): _____

- In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : _____

- Have you:
Thought you had a thyroid problem, but not had a diagnosis: Y N
Been tested for an auto-immune (Hashimoto's) thyroid condition: Y N
Been diagnosed with an auto-immune thyroid condition: Y N
- Symptoms(list all):

- What relieves your symptoms or causes them to return:

- If your symptoms include pain:
What is the quality (sharp, dull, stabbing, color, etc.): _____
Does the pain radiate: Y N: _____

- Are you currently taking thyroid hormones:Y N
What symptoms persisted AFTER taking thyroid hormones:

- What are the three things your condition has caused you to miss :

- Severity (circle):
Minimal (annoying but causing no limitation)
Slight (tolerable but causing a little limitation)
Moderate (sometimes tolerable but definitely causing limitation)
Severe (causing significant limitation)
Extreme (causing near constant limitation (>80% of the time))
- Describe the first time you remember having symptoms:

- Do your symptoms occur at a specific time, place, or environment:Y N
When and for how long do symptoms last each episode:

- List your health goals in order of Importance:



13. What are you hoping happens today as a result of your consultation:

15. If you cannot find a solution to your problem what do you think will happen?

Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10
 14. Due to your condition have you lost time from?
 Work: Y N Describe:
 Family: Y N Describe:
 Leisure Activities Y N Describe:

Medical and Social History

Surgeries/Hospitalizations	Date	Trauma	Date
_____	_____	_____	_____
_____	_____	_____	_____
Past/Recent Illness	Date	Marital Status: S/ M/W/Sep./D	Spouse_____
_____	_____	Children / ages:	_____
_____	_____	_____	_____
Family History (mother, father, siblings, spouse, children)	Date	Do you use: Alcohol Y N	Tobacco Y N
_____	_____	_____ drinks/week	_____ pack/day
_____	_____	_____	_____ cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL	GENITOURINARY	ENDOCRINE	NEUROLOGICAL
PC Fatigue	PC Frequent urination	PC Glandular or hormone problem	PC Freq./ recurring headaches
PC Recent weight change	PC Burning or painful urination	PC Excessive thirst or urination	PC Migraine headache
PC Fever	PC Blood in urine	PC Heat or cold intolerance	PC Convulsions or seizures
	PC Change in force or strain urinating	PC Skin becoming dryer	PC Numbness or tingling
EYES	PC Kidney stones	PC Change in hat or glove size	PC Tremors
PC Blurred/double vision	PC Sexual difficulty	PC Diabetes	PC Paralysis
PC Glasses/contacts	PC Male : testicle pain	PC Thyroid Disease	PC Head injury
PC Eye disease or injury	PC Female: pain / irregular periods		PC Light headed or dizzy
	PC Female: pregnant	MUSCULOSKELETAL	PC Stroke
EAR/NOSE/MOUTH/THROAT	PC Bladder Infections	PC Back pain	
PC Swollen glands in neck	PC Kidney Disease	PC Joint pain	HEMATOLOGIC/LYMPHATIC/OTHER
PC Hearing loss or ringing	PC Hemorrhoids	PC Joint stiffness and swelling	PC Slow to heal after cuts
PC Earaches or drainage		PC Muscle pain or cramps	PC Easy bleeding or bruising
PC Chronic sinus problems or rhinitis	GASTROINTESTINAL	PC Muscle or joint weakness	PC Anemia
PC Nose bleeds	PC Abdominal pain	PC Difficulty walking	PC Phlebitis
PC Mouth sores / Bleeding gums	PC Nausea or Vomiting	PC Cold extremities	PC Past transfusion
PC Bad breath / bad taste	PC Rectal bleeding/blood in stool		PC Enlarged glands
PC Sore throat or voice change	PC Painful bm / constipation	INTEGUMENTARY (skin, breast)	PC Blood or Plasma Transfusions
	PC Ulcer	PC Change in skin color	PC Hepatitis



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CARDIOVASCULAR

- PC High or Low Blood Pressure
- PC Shortness of breath walking/lying
- PC Heart disease
- PC Chest pain or angina pectoris
- PC Palpitation
- PC Mitral Valve Prolapse
- PC Feet or ankle swelling
- PC Shortness of breath
- PC Spitting up blood

PSYCHIATRIC

- PC Insomnia
- PC Memory loss or confusion
- PC Nervousness
- PC Depression

- PC Change in bowel movement
- PC Frequent diarrhea
- PC Loss of appetite

RESPIRATORY

- PC Chronic or frequent cough
- PC Spitting up blood
- PC Pneumonia / Bronchitis
- PC Shortness of breath
- PC Wheezing
- PC Asthma

- PC Change in Hair or Nails
- PC Varicose veins
- PC Breast pain / discharge
- PC Breast lump
- PC Hives or Eczema
- PC Rash or itching

- PC Cancer
- PC Infectious Mono
- PC AIDS or HIV+
- PC Venereal
- PC Chicken pox

ALLERGIES / OTHER (drugs, food, or environmental) _____

RECENT TESTS (lab work, x-rays, CT, MRI) _____

MEDICATION (Rx, OTC, botanicals, homeopathic, and supplements)
