Thyroid Screening Questionnaire

Which symptoms are you currently experiencing?

☐ Fatigue
☐ Unexplained weight gain
☐ Unexplained weight loss
☐ Feeling unusually cold
☐ Feeling unusually warm
☐ Constipation
☐ Frequent bowel movements
☐ Dry skin
☐ Hair thinning or hair loss
☐ Muscle weakness or aching
☐ Rapid or irregular heartbeat
☐ Anxiety or shakiness
☐ Depressed mood
☐ Difficulty concentrating
☐ Neck swelling or pressure
☐ Difficulty swallowing
☐ Other: _____

Have you previously been told that you have a thyroid condition?

☐ Yes
☐ No
☐ Unsure

How much are these symptoms affecting your quality of life?

☐ Mildly
☐ Moderately
☐ Significantly

What is your primary thyroid-related concern?

_____