Henley Chiropractic Center - Hypothyroidism Check List

Patients Name: _____ Date: _____

(Circle No or Yes . . . please answer all questions)

1. Do you have hoarseness of your voice that has not always been present? . No Yes
2. Do you have swelling of your face? . . . . . .No Yes
3. Have you ever had swelling or a goiter in the lower front of your neck? . . . . No Yes
4. Are you usually sensitive to alcoholic beverages or to an anesthetic or sedative drugs? . . . . . No Yes
5. Do you have dry, scaly skin? . . . . . No Yes
6. Do you have unusual whiteness or pallor of your skin? . . . . . .No Yes
7. Have you ever had a yellow color to your skin or nails? . . . . . No Yes
8. Do you have decreased sweating? . . . . . No Yes
9. Has your hair become drier and more coarse? . . . . . No Yes
10. Do you have a decrease in eyebrows toward the side of the face? . . . . . No Yes
11. Have you had a decrease in the amount of scalp hair? . . . . . .No Yes
12. Have you notices a “dirty” or thickened skin appearance of you elbows & knees? . . . . . .No Yes
13. Do you have delayed reflexes? . . . . . No Yes
14. Do you have persistent numbness & tingling in any part of your body extremities? . . . . . No Yes
15. Do you get all tired out easier than you used to? . . . . . No Yes
16. Have you ever had protruding eyeballs? . . . . . No Yes
17. Do you have swelling around the eyes or of the eyelids? . . . . . No Yes
18. Do you often have blood-shot eyes? . . . . . No Yes
19. Do you have excessive tearing of your eyes? . . . . . No Yes
20. Have you ever been told you you had an enlarged heart? . . . . . No Yes
21. Do your ankles swell or do you otherwise notice evidence of body fluid retention? . . . . . No Yes
22. Have you ever been told you had an abnormal electrocardiogram? . . . . . No Yes
23. Do you have less than normal energy? . . . . . No Yes
24. Have any of your blood relatives had thyroid gland disease? . . . . . No Yes
25. Do you have headaches? . . . . . No Yes
26. Does cold temperature bother you in the sense that you like the room temperature higher than other people or you wear more clothing or need more bedcover than others? . . . . . No Yes
27. Do you have difficulty in pronouncing words? . . . . . No Yes
28. Have you ever felt pain in the lower front part of your neck?. . . . . No Yes
29. Have you had an unexplained increase in weight recently? . . . . . No Yes
30. Do you have rough skin or weakened nails that have not always been this way? . . . . . No Yes

31. Do you have difficulty in concentrating? . . . . . No Yes
32. Are you usually forgetful? . . . . . No Yes
33. Do you feel that you are emotionally unstable but that this been only in recent weeks or months? . . . . . .No Yes
34. Do you feel tired after a usual night of sleep or has your sleep or rest requirement increase? . . . . . No Yes
35. Do you have blurred vision? . . . . . No Yes
36. Do you have ringing of the ears? . . . . . No Yes
37. Do you have dizzy spells? . . . . . No Yes
38. Do you have a decrease in your ability to hear? . . . . . No Yes
39. Are you inclined to be more nervous than is customary for you? . . . . . .No Yes
40. Do you have times when you have difficulty breathing? . . . . . .No Yes
41. Have you ever been told that you had angina (heart pain)? . . . . . .No Yes
42. Do you sometimes have an attack of rapid or irregular heart beats? . . . . . No Yes
43. Do you have dyspepsia or indigestion? . . . . . .No Yes
44. Do you have an excess of saliva? . . . . . .No Yes
45. Do you frequently fell nauseated? . . . . . .No Yes
46. Do you have abdominal swelling? . . . . . .No Yes
47. Do you have any abdominal pain? . . . . . No Yes
48. Have you ever had gall bladder trouble? . . . . . No Yes
49. Do you have constipation, or difficult bowel movement? . . . . . No Yes
50. Do you frequently have diarrhea? . . . . . No Yes
51. Is there any problem with sex drive? . . . . . No Yes
52. Is there any problem concerning having children? . . . . . No Yes
53. Do you have an increased menstrual flow? . . . . . No Yes
54. Do you have an absence of menstrual periods? . . . . . No Yes
55. Do you have irregular menstrual periods? . . . . . No Yes
56. Has there been a change in your menstrual pattern? . . . . . No Yes
57. Do you have generalized aches? . . . . . No Yes
58. Do you have joint paints? . . . . . .No Yes
59. Have you ever had difficulty swallowing? . . . . . .No Yes

Count Total # of Yes answers _____

Dr . Notes: _____

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