CENTER FOR ALTERNATIVE MEDICINE

PATIENT QUESTIONNAIRE

Thyroid Assessment Questionnaire

Name _____ Date _____

CHECK IF YES

1. ☐ Chronically tired, sluggish
2. ☐ Feel cold – hands, feet, all over
3. ☐ Tight sensation in neck
4. ☐ Difficult, infrequent bowel movements
5. ☐ Dry, discolored skin, dry hair
6. ☐ Thick brittle nails
7. ☐ Puffy face, hands, and feet
8. ☐ Swollen upper eyelids
9. ☐ Eyeballs move involuntarily
10. ☐ Muscles weak, cramp, and/or tremble
11. ☐ Slow mental processes, forgetfulness
12. ☐ Slow heart beats
13. ☐ Abdominal bloating / swelling
14. ☐ Unsteady gait, movements / loss of balance
15. ☐ Lack of interest in sex
16. ☐ Gain weight easily
17. ☐ Swelling of the neck
18. ☐ Outer third of eyebrow thins
19. ☐ Thinning hair on scalp, face and genitals
20. ☐ Loss of appetite
21. ☐ Premenstrual tension
22. ☐ Infertility
23. ☐ Excessive menstrual bleeding / heavy flow
24. ☐ Absence of / missed periods

Total Checked _____

INTERPRETATION

Score less than 3	Low probability of thyroid dysfunction
Score 3 to 8	Moderate probability of thyroid dysfunction
Score 9 or more	High probability of thyroid dysfunction