THYROID DISORDER

SCREENING FORM

PERSONAL INFORMATION

Full Name :

Age :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number :

Gender : Male Female

SYMPTOMS AND HISTORY

Any changes in weight (gain or loss)?

Heat or cold intolerance:

Changes in bowel habits (Diarrhea, constipation):

History of anxiety, depression, or mood disorders:

Hair loss:

Family history of thyroid disorders:

Any eating or sleeping disorders:

Changes in menstrual cycles:

THANK YOU FOR YOUR INFORMATION