INTAKE FORM - THYROID

Name: _____ DOB (dd/mm/yyyy): _____

What thyroid issues prompted your referral to Dr. Mabini? (please circle):

Hyperthyroidism Hypothyroidism Thyroid nodules Thyroid cancer

Other: _____

Do you have any of the following symptoms? (please check if yes):

- ☐ Palpitations (feeling like your heart is beating too fast or skipping beats)
- ☐ Anxiety, restlessness, irritability
- ☐ Fatigue
- ☐ Heat intolerance / hot flashes
- ☐ Shakiness
- ☐ Difficulty sleeping
- ☐ Irregular menstrual cycles
- ☐ Diarrhea
- ☐ Hair loss
- ☐ Weight loss
- ☐ Weight gain
- ☐ Constipation
- ☐ Cold intolerance
- ☐ Dry skin
- ☐ Depressed mood
- ☐ Brain fog/memory problems
- ☐ Trouble breathing when lying flat
- ☐ Trouble swallowing
- ☐ Voice hoarseness

Do you see an endocrinologist for your thyroid? If yes, who?: _____

Are you on any medications for your thyroid issues? If yes, please list medications and dosages:

_____

Has anyone in your family had thyroid issues, such as cancer? If yes, please state who:

_____

Do you have a history of radiation exposure?: _____

Have you had any relevant imaging? (thyroid ultrasound, etc.). If yes, when and where was the test done? _____

Have you ever had a thyroid biopsy? (please list approximate date and results):

_____