PCCA CONFIDENTIAL
THYROID HORMONE EVALUATION

Today's Date: _____

Name: _____ DOB: ____/____/____ Age: _____

Address: _____

City, State, Zip: _____

Phone: Day: _____ Evening: _____

E-mail Address: _____

Gender: Male _____ Female _____ Height: _____ Wt: _____

Current Physicians:

Name	**Address**	**Phone Number**

Patient Name: _____

Social History:

Have you ever used tobacco? If so, how often and how much? _____

_____

Have you ever used alcohol? If so, how often and how much? _____

_____

Do you use caffeine? If so, how often and how much? _____

_____

Do you exercise? If so, what type, how long, how often? _____

_____

Medical History:

Please list any allergies: (medication, pet, seasonal, food, dyes) _____

_____

_____

Please describe the allergic reaction you experienced and when it occurred: _____

_____

_____

Do you take any over-the-counter medications, nutritional or protein supplements (including SOY), or herbal/homeopathic medications and list for what reason:

_____

_____

_____

_____

Patient Name: _____

Medical Conditions/Diseases: Please check all that apply.

____ Cardiovascular (heart failure, heart attack)
____ Hyperlipidemia (elevated cholesterol or lipids)
____ Hypertension (high blood pressure)
____ Cancer
____ Hyperthyroid
____ Hypothyroid
____ Asthma, emphysema, COPD or other lung disorders
____ Hormonal related issues
____ Arthritis
____ Depression
____ Epilepsy
____ Ulcers
____ Diabetes
____ Anemia (Iron Deficiency)
____ Blood clotting problems
____ Stroke

Do you have a history of whiplash or other neck injuries? If so, please describe and include date occurred. _____

_____

_____

_____

Are you currently taking: (Please circle.)

Amiodarone (Cordarone®)
Carbamazepine (Tegretol®)
Levo/Carbidopa (Sinemet®)
Androgens (Testosterone, DHEA)
Danocrine (Danazol®)
Phenytoin (Dilantin®)
Metoclopramide (Reglan®)
Lithium
Estrogens (patch, tablets, topical, oral contraceptives)
Glucorticoids (hydrocortisone, prednisone, prednisolone, etc.)
Cholestyramine (Questran®, Prevalite®)

Current Prescription Medications:

Medication Name	Strength	# Per Day	Date Began

Patient Name: _____

PCCA Confidential Thyroid Hormone Evaluation

PATIENT SELF-ASSESSMENT

SYMPTOMS	ABSENT	MILD	MODERATE	SEVERE
Depression				
Weight gain				
Cold extremities				
Cold intolerance				
Feel chilly				
Dry hair				
Brittle hair				
Dry skin				
Eczema				
Acne				
Puffy eyelids, face				
Brittle nails				
Menorrhagia				
Constipation				
Mentally sluggish				
Headache				
Insomnia				
Early morning fatigue				
Late morning fatigue				
Evening fatigue				
Muscle cramps				
Low sex drive				

When did symptoms start? _____

_____

_____

_____

Any family history of ANY thyroid diseases? Please list whom and what type (goiter, hypothyroidism, hyperthyroidism, Graves Disease, Hashimoto's Disease).

_____

_____

_____

_____

_____

Patient Name: _____

Have you ever been tested for thyroid problems? Please list doctor, when diagnosed, and any therapy given. _____

_____

_____

_____

_____

_____

Do you have any current lab results (TSH, T4, Free T4,T3, Free T3, rT3, Lipid panel, Hemoglobin, Iron, etc.)? Please provide documentation.

_____

_____

_____

_____

_____

_____

Have you had any other additional thyroid tests performed? _____

_____

_____

_____

_____

DISCLAIMER: By signing this form, I authorized the release of my medical information to share with other healthcare professionals for treatment purposes only.

_____