Gwinnett Surgical Associates
THYROID QUESTIONAIRE
This form is to be filled out only by Thyroid patients.

Patient Name: _____ **Provider:** _____

Date of Birth: _____ **Today's Date:** _____

- What type of Thyroid issue do you have? (Circle your answer) Nodules Hypothyroidism Hyperthyroidism
  Graves Disease Hashimoto's Other (specify) _____
  - Date of initial diagnosis _____
    - How was the diagnosis of Thyroid disease made? _____

- How long have you had symptoms of a Thyroid abnormality? _____
  - Do you have symptoms? YES NO
    - If yes, please specify AND is it progressively getting worse? _____

- Does anyone in your family have Thyroid disease? YES NO
  - If yes, please specify whom in the family _____

- Are you currently taking any Thyroid Medications? YES NO
  - If yes, please list _____

- Do you have a history of high dose radiation which involve radiation therapy for malignancy?
  YES NO
  - If yes, please list approximate age of diagnosis _____

- Do you or anyone in your family have a history involving Endocrine Abnormalities? YES NO
  - If yes, please provide who in the family and the type of abnormality _____

- Have you had any diagnostic testing for the Thyroid? YES NO
  - (Please circle type of testing) XRAY Ultrasound MRI
    Biopsy: Fine Needle Aspiration CT Scan Other _____

- Are there Thyroid nodule/nodules present? YES NO
  - If yes, is it/are they enlarging? YES NO

FOR OFFICE USE ONLY:

1. Serum TSH _____
2. Radiograph results (Ultrasound, MRI, CT) _____
3. Results of FNA (Bethesda Classification _____

Other Information: _____