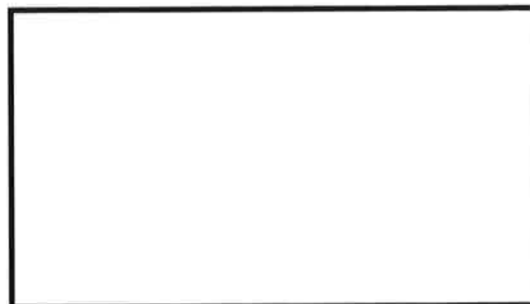
Hypothyroidism Patient History



Patient Information

Name: ____________________

Address: ____________________

Phone No.: ____________ Sex: ____ Date of Birth: ____________

General Health: ____________________

Please indicate whether you eat the following foods or take the following nutritional supplements on a daily or regular basis:

FOOD/SUPPLEMENT	FREQUENCY OF CONSUMPTION		
	DAILY	WEEKLY	AS NEEDED
Soy Milk			
Soy-based Foods			
Grapefruit			
Coffee			
Papaya			
High-fiber Foods			
Walnuts			
Calcium Supplements			
Iron Supplements			
Chromium			
Chromium Picolinate			
Foods High in Iodine (Sushi, Seaweed, etc.)			
Orange Juice			
Tea			

Please indicate whether you take the following prescribed or over-the-counter (OTC) medicines:

PRODUCT NAME	FREQUENCY OF CONSUMPTION		
	DAILY	WEEKLY	AS NEEDED
Prilosec			
Prevacid			
Tagamet			
Milk of Magnesia			
Tums			
Maalox			
Pepcid			
Zantac			
Zegerid			
Rollaids			
Other Antacids			

Question		
How long have you taken the same brand or generic T4 drug?		
What time each day do you take your thyroid medication?		
Do you take your thyroid medicine on an empty stomach?	☐ Yes	☐ No
About what time daily do you take your thyroid medicine?		
Do you drink coffee? How many cups of coffee do you drink daily?		
When do you have your first cup of coffee each day?		
Are you taking nutritional supplements? If so, which ones?		
Have you been diagnosed with celiac disease?	☐ Yes	☐ No
Has anyone in your family been diagnosed with celiac disease?	☐ Yes	☐ No
What type of food allergies do you have that you are aware of? ☐ Peanut ☐ Tree Nuts ☐ Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Fish ☐ Shellfish ☐ Other (please list)		
Do you take over-the-counter or prescribed drugs for any GI problems such as acid reflux (indigestion)? If so, how often do you take them?		
Have you undergone GI surgery within the past 24 months if yes, what type of surgery?	☐ Yes	☐ No
Do you have any of the following: ☐ H. Pylori ☐ Gastritis ☐ Auto-Immune Disease ☐ Crohns Disease ☐ Irritable Bowel Syndrome ☐ Peptic Ulcers ☐ Lupus ☐ GI Issues ☐ Other:		
Do you experience lactose intolerance? If so, to what degree?		
Do you have any liver problems?	☐ Yes	☐ No
Are you taking a weight loss drug or nutritional supplement?	☐ Yes	☐ No
Have you or has anyone in your family been diagnosed with celiac disease?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Do you miss doses of your T4 therapy? If yes, how frequently?	☐ Yes	☐ No

Signature: ____________________ Date: ____________