THYROID DISORDERS QUESTIONNAIRE QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)

1. PATIENT'S INFORMATION

Name	Last	Fist Name	Initial
Date of Birth	MM / DD / YYYY		

2. DIAGNOSIS

Please provide details about when the condition was diagnosed:

Date of Diagnosis: MM / DD / YYYY   Diagnosis: ☐ Hyperthyroidism ☐ Hypothyroidism

Cause: ☐ Serious diseases ☐ Simple Goiter ☐ Nodular Goiter ☐ Thyroiditis ☐ Thyroiditis Hasimoto
☐ Medical ☐ Iodine deficiency ☐ Thyroid nodule ☐ Thyroid malignancy
☐ Congenital ☐ Pituitary adenoma ☐ Other (specify):

Is the patient under treatment? ☐ Yes ☐ No   If "Yes", please provide details.

Has radioactive iodine been administered? ☐ Yes ☐ No

Has the patient undergoing any of the following procedures?
Biopsy ☐ Yes ☐ No   Total thyroidectomy ☐ Yes ☐ No   Partial thyroidectomy ☐ Yes ☐ No
If you answer yes to any of the above, please include the pathology report

Please provide the following information:
Blood test values no longer than 6 months (Please include the lab report):
TSH ☐   T4 ☐   Antithyroid peroxidase antibody ☐
Thyroid ultrasound result (no longer than 1 year). Omit only in case of total thyroidectomy

Has the patient undergone thyroid gamagrama? ☐ Yes ☐ No   If "Yes", please provide details.

If you have had thyroid cancer, please attach complete medical record

Are there other diseases, complications, factors or symptoms that have not been mentioned before? ☐ Yes ☐ No
If you answer yes to any of the above, please include the pathology report

3. TREATING PHYSICIAN'S INFORMATION

Name	Last	Fist Name	Initial
Address			
Telephone		Fax	
Email			

4. SIGNATURE

Physician's signature		Date	MM / DD / YYYY
Physician's signature		Date	MM / DD / YYYY

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