Thyroid and Parathyroid Surgery Health History Questionnaire

**Personal Health History**
Check if you have had any of the following:

- Thyroid Cancer
- Thyroid Nodules
- Goiter
- Labile Hypertension
- Osteopenia
- Osteoporosis
- Scar Keloid
- Elevated Parathyroid Hormone Level (PTH)
- Elevated Serum Calcium Level
- Kidney Stones

**Current Health Concerns**
Please check problems or conditions that you are CURRENTLY experiencing:

- Chest pain
- Bone pain
- Depression
- Shortness of breath
- Neck pain
- Poor concentration
- Fast heartbeat
- Flank pain
- Irritability
- Cough
- Muscle weakness
- Nervousness
- Coughing up of blood
- Involuntary movements
- Excessive sweating
- Hemorrhoids
- Difficulty swallowing
- Flushing
- Rectal bleeding
- Painful swallowing
- Itching
- Diarrhea
- Eye pain
- Brittle nails
- Weight loss (lbs. )
- Memory lapses or loss
- Loss of hair
- Weight gain (lbs. )
- Earache
- Hyperthermia (feeling hot)
- Loss of appetite
- Hoarseness
- Hypothermia (feeling cold)
- Increased appetite
- Fatigue
- Other:
- Body aches and pains
- Insomnia

**Family History**
Please check all that apply:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
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<tbody>
<tr>
<td>Thyroid Cancer</td>
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<td>Elevated Serum Calcium Level</td>
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<td>Osteoporosis</td>
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<td>Kidney Stone</td>
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<td>MEN Syndrome</td>
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<tr>
<td>Elevated Parathyroid Hormone Level</td>
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<td>None of the above</td>
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Patient/Guardian Signature: ____________________________ Date: __________________

Rev. 07/2021
Scanning Category: Administrative/Patient Forms