



## Thyroid and Parathyroid Surgery Health History Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Personal Health History	Previous Surgical Procedures	
Check if you have had any of the following	Previous Surgical Procedures	
<input type="checkbox"/> Thyroid Cancer	Procedure	Year
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Neck surgery	
<input type="checkbox"/> Labile Hypertension	<input type="checkbox"/> Cervical spinal fusion	
<input type="checkbox"/> Osteopenia	<input type="checkbox"/> Cervical Laminectomy	
<input type="checkbox"/> Scar Keloid	<input type="checkbox"/>	
<input type="checkbox"/> Elevated parathyroid hormone level	<input type="checkbox"/>	
<input type="checkbox"/> Elevated Serum Calcium Level		

Current Health Concerns		
Please check problems or conditions that you are CURRENTLY experiencing		
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Bone pain	<input type="checkbox"/> Depression
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Poor concentration
<input type="checkbox"/> Fast heartbeat	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Irritability
<input type="checkbox"/> Cough	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Coughing up of blood	<input type="checkbox"/> Involuntary movements	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Flushing
<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Itching
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Brittle nails
<input type="checkbox"/> Weight loss (lbs. )	<input type="checkbox"/> Memory lapses or loss	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Weight gain (lbs. )	<input type="checkbox"/> Earache	<input type="checkbox"/> Other:
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Fatigue	
<input type="checkbox"/> Body aches and pains	<input type="checkbox"/> Insomnia	

Family History				
Please check all that apply				
	Father	Mother	Brother	Sister
Thyroid Cancer				
Elevated Serum Calcium Level				
Osteoporosis				
Kidney Stone				
MEN 2A Syndrome				
Elevated Parathyroid Hormone Level				
None of the above				

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_