BITTEN JONSSON Reg. Nurse, Leg.SSK
Board of Directors Food Addiction Institute http://foodaddictioninstitute.org
Faculty member INFACT, www.infact.is

Send whole form back

Thyroid Assessment Questionnaire

Name **Date**

Please complete the tables below answering the questions below by checking the yes or no box or marking with an X

Symptom	Yes	NO
Palpitations (rapid or forceful heart beat)		
Poor concentration		
Memory loss		
Difficulty sleeping		
Excessive need for sleep		
Fatigue		
Weak Muscles		
Sore Muscles		
Agitation/Anxiety		
Depression		
Dry Skin		
Itchy Skin		
Unusual hairloss		
Dry hair		
Cracking nails		
Infrequent bowel movements or hard stools		
Frequent bowel movements or loose stools		
Unexplained weight gain		
Unexplained weight loss		
Persistent pain or swelling in front of neck		
Hoarseness		
Sensation of a lump in the throat		
Eye pain or double vision		
Swelling or protrusion of eyes		
Change in facial appearance		
Sweating		
Difficulty tolerating cold		

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bitten.jonsson@bittensaddiction.com www.bittensaddiction.com

Difficulty tolerating heat		
Hand Tremor		

Complete if Women before menopause	**Yes**	**NO**
Loss of menstrual periods		
Irregular periods		
Excessive menstrual flow		
Pregnant		
Miscarried		

Do you have family members with Diagnosis of Thyroid disease, identify which disease	**Yes**	**NO**
Overactive thyroid gland		
Underactive thyroid gland		
Nodule or enlarged thyroid gland		
Thyroid cancer		
Unknown thyroid disease		
Other		

Do have ever been diagnosed with a Thyroid disease?	**Yes**	**NO**
Overactive thyroid gland		
Underactive thyroid gland		
Nodule or enlarged thyroid gland		
Thyroid cancer		
Other		

Are you currently being treated for a thyroid disease?	**Yes**	**NO**
Thyroid hormone therapy (synthroid, eltroxin, cytomel)		
Antithyroid drug therapy (PTU, tapazole)		

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Other		

Have you been treated for a thyroid disease in the past?	**Yes**	**NO**
Thyroid hormone therapy (synthroid, eltroxin, cytomel)		
Thyroid Surgery		
Radioiodine Therapy (not diagnostic scan)		
Ant thyroid drug therapy (PTU, tapazole)		
Other:		

Do you currently take any herbal remedies or dietary supplements specifically to benefit your thyroid? Please List below	**Yes**	**NO**

Do you have the following medical problems?	**Yes**	**NO**
High blood pressure		
High cholesterol		
Heart disease or Angina (chest pain)		

Do you take any of the following	**Yes**	**NO**
Cholestyramine		
Amiodarone		
Lithium		

Thank you Bitten

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