Lake Huron Medical Group

Patient Name: _____

Date of Birth: (Month)_____ (Day)_____ (Year)_____

Please circle YES or NO to the questions listed below:

1. Weight Loss…… YES No
2. Weight Gain…… YES No
3. Heat Intolerance……..YES No
4. Cold Intolerance ……..… YES No
5. Nervousness or Anxiety…….. YES No
6. Heart Palpitations……YES No
7. Chest Pain…… YES No
8. Shortness of Breath……YES No
9. Constipation……YES No
10. Diarrhea…….. YES No
11. Muscle Cramps……. YES No
12. Muscle Weakness…….. YES No
13. Dry Skin……..YES No
14. Brittle Nails……..… YES No
15. Hair Loss……. YES No
16. Dysphagia (Trouble Swallowing)…… YES No
17. Hoarseness of Voice……..…….. YES No
18. Choking Sensation……..…….. YES No
19. Energy (Good, not fatigue)…… YES No