

**Thyroid Center of San Francisco**  
History and Physical Information

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

The **Main Reason** for your visit today? \_\_\_\_\_ How long has this problem existed? \_\_\_\_\_

**THYROID HISTORY** Check & Describe all that apply:

Low Iodine Diet:
Head and Neck Radiation:
Family History (Goiter, Thyroid Cancer):
Genetic Conditions (Garner Syndrome, Cowden Disease, adrenal tumor, pituitary tumor):
Anti-Coagulation / Bleeding Issues:
Obstruction Issues:
Swallowing Difficulties:
Radioactive Iodine Therapy:
Thyroid Surgery:
Other:

**ALLERGIES TO MEDICATIONS:**  **NONE**

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**OTHER ALLERGIES:** (foods, pollen, eggs, iodine, shellfish, latex, etc.)  **NONE**

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**MEDICATIONS:** List all prescription and NON-prescription medications (such as Motrin, vitamins, herbal supplements, Mucinex, Tylenol, etc.) that you are taking.  **NONE**


**CURRENT ISSUES** Check all that apply:

Hearing problems	Frequent sore throats	Unintentional weight loss
Ringing in the ears	Sores/ulcers in mouth	Hoarseness
Dizziness	Heartburn	Swallowing problem
Nasal discharge	Cough	Swollen lymph nodes
Sinus infections	Skin Rash	Heat/ Cold Intolerance
Head trauma	Joint pain / swelling	Fever / chills / night sweats
Snoring / sleep problem	Weakness	Fatigue
Mouth breathing	Bleed / bruise easily	Increased Thirst
Headache / Migraine	Nausea / Vomiting	Appetite changes
Chest pain	Abdominal pain	Salivary gland problem
Shortness of breath	Change in bowel habits	Vision changes
Swelling in hands / feet	Frequent urination	Eye Pain
Difficulty breathing	Urgency / Incontinence	Changes in sensation
Wheezing	Pain with urination	Mental status changes

**PAST HOSPITALIZATIONS/SURGERIES** Indicate year and the reason (omit normal pregnancies):

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**MEDICAL HISTORY** Check & Describe all that apply to you:

<input type="checkbox"/>	AIDS/HIV - last viral load?
<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Anesthesia issues
<input type="checkbox"/>	Anxiety disorder
<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Attention deficit disorder
<input type="checkbox"/>	Autoimmune disease
<input type="checkbox"/>	Bleeding disorders
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Eye disease
<input type="checkbox"/>	GI disorder/Reflux

<input type="checkbox"/>	Headaches / Migraine
<input type="checkbox"/>	Heart attack - when?
<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Lung disease
<input type="checkbox"/>	Mitral Valve prolapse
<input type="checkbox"/>	Muscle / bone disorder
<input type="checkbox"/>	Neurological disorder
<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	Skin rash
<input type="checkbox"/>	Thyroid disorder (see above)
<input type="checkbox"/>	Urinary/kidney disorder

**PREVIOUS TESTS PERFORMED** List body part, date and facility:

<input type="checkbox"/>	Ultrasound:
<input type="checkbox"/>	Xray or MRI:
<input type="checkbox"/>	Thyroid Function Tests:

**SOCIAL HISTORY:**

Cigarette Use: ____cigarettes / day for ____ years. If you have quit, how long ago? _____	
Are there smokers in the house, even if they do not smoke inside? No / Yes	
Alcohol: ____drinks / week	Recreational Drug Use: No / Yes _____
Coffee / Tea: ____cups / day	Occupation:

**FAMILY HISTORY** Check all that apply for your sibilngs, parents and grandparents:

<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Anesthesia issues
<input type="checkbox"/>	Bleeding disorders
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Hearing Loss

<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Psychiatric Illness
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Sudden Death
<input type="checkbox"/>	Thyroid Disease (see first page)

**PREGNANCY:**

Are you pregnant, OR trying to get pregnant ? Yes / No

Form completed by (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_