Village Health Partners
Aparna Ayyagari, MD

Patient History – Thyroid Visit Only

Patient Name: _____ **Date of Birth:** _____

Reason for Visit (please circle): - Enlarged thyroid - Thyroid nodule - Underactive thyroid - Overactive thyroid - Thyroid cancer

PLEASE COMPLETE ONLY THE SECTION THAT PERTAINS TO YOUR VISIT

Section 1: Thyroid

___ Anxiety or depression
___ Constipation/diarrhea
___ Fatigue
___ Heat/cold intolerance
___ Milk discharge from breast
___ Sore throat
___ Swelling of leg
___ Vision change
___ Brittle nails
___ Clearing throat frequently
___ Hair loss
___ Hoarseness
___ Pain over thyroid
___ Sweating
___ Tingling around mouth/hands
___ Weight gain/loss
___ Coarse hair
___ Difficulty concentrating
___ Headache
___ Irregular periods
___ Palpitations
___ Swelling of eye or eye lid
___ Tremors

___ Other _____

Are you currently pregnant? Yes/No _____ Thyroid issues during prior pregnancies? Yes/No _____

Section 2: Thyroid Nodule

___ Cough
___ Hoarseness
___ Pressure over neck
___ Current or former smoker
___ Neck mass/nodule
___ Shortness of breath
___ Difficulty swallowing
___ Neck pain or tenderness
___ Sore throat
___ Prior radiation exposure to head/neck If yes, Date _____ Reason _____
___ Family history of thyroid cancer
___ Other _____

Please document any tests or treatments that you have previously experienced, then provide as much detail as possible so we can obtain your records. If you are unsure of an answer, please leave blank.

___ Ultrasound of thyroid _____
_____

___ Thyroid scan and uptake (this is a nuclear medicine test) _____
_____

___ Thyroid nodule biopsy (US-guided FNA) _____
_____

___ Thyroid surgery (removal of half or all of your thyroid) _____
_____

___ Thyrogen whole body scan (for thyroid cancer patients) _____
_____

___ Radioactive Iodine treatment either for thyroid cancer or overactive thyroid/Graves' _____
_____