

THYROID QUESTIONNAIRE

Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s):	Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any auto/work related injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- Is it under-active (hypothyroid or over-active (hyperthyroid)? _____
- When first diagnosed? _____
- Type of treatment?
 - Current treatment: _____
 - How often is treatment? _____
 - If treatment stopped, when? _____
 - Any future treatment planned? Yes No
- Current medications – names, milligrams (pill or shot): _____
 - How often? _____
- Any radioactive iodine treatment? Yes No
 - When? _____
 - Results: _____
- Any surgery? Yes No
 - When? _____
 - Inpatient Outpatient
 - For how long? _____
 - Any future surgery planned? Yes No
- Any cancer involved
- Any benign tumors/growths/cysts? Yes No
- Last time seen by a Doctor for this condition: _____
 - Doctor's name and address: _____

Notes: _____

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

Signature

Date