Low Thyroid Function

Name: _____ Date: _____

1.	Difficulty losing weight no matter what diet or exercise plan you follow.	Yes
2.	Mentally sluggish, problems with focus, difficulty concentrating and/or remembering.	Yes
3.	Depression and/or lack of motivation (reduced initiative).	Yes
4.	Easily fatiqued and/or low stamina.	Yes
5.	Do you feel exhausted from morning to night and/or sleepy during the day?	Yes
6.	Increased sensitivity to cold and/or being colder than other people around you.	Yes
7.	Poor circulation (cold hands and/or feet, or all over the body) and/or wearing socks to bed.	Yes
8.	Are you constipated despite adequate fiber and/or liquids?	Yes
9.	Do you experience your hair as feeling like straw, dry, coarse and/or easily falling out.	Yes
10.	Morning headaches that wear off as the day progresses.	Yes
11.	Loss and/or thinning of outer third of eyebrow.	Yes
12.	Seasonal sadness.	Yes
13.	Do you have trouble getting up in the morning and/or do you wake up tired.	Yes
14.	Do you experience aches or pains in muscles and/or joints unrelated to trauma or exercise?	Yes
15.	Difficult and/or infrequent bowel movements.	Yes
16.	Dryness and/or discoloration of the skin.	Yes
17.	Brittle nails and/or excess breaking of nails.	Yes
18.	Puffy face, hands and/or feet.	Yes
19.	Do you or family members have diabetes, anemia, rheumatoid arthritis and/or early graying of hair.	Yes
20.	Do you have increased problems with digestion and/or allergies?	Yes
21.	Is your short term memory getting worse and/or do you experience forgetfulness?	Yes
22.	Weak, cramping and/or trembling of muscles.	Yes
23.	Slow heart beat.	Yes
24.	Abdominal swelling.	Yes
25.	Unsteady gait, movements and/or off balance.	Yes
26.	Lack of interest in sex and/or low sex drive.	Yes
27.	Gain weight easily.	Yes
28.	Swelling of the neck.	Yes
29.	Thinning of hair on scalp, face and/or genitals.	Yes

30.	Loss of appetite.	Yes
31.	Do you have PMS, ovarian cysts, endometriosis and/or other gynecological problems?	Yes
32.	Have you had trouble conceiving a child (unable to get pregnant).	Yes
33	Have you had miscarriages, stillbirths and/or premature deliveries?	Yes
34.	Absence of periods.	Yes
35.	Requires excessive amounts of sleep to function normally.	Yes
36.	Increase in weight gain even with low calorie diet.	Yes
37.	Dryness of the hair and/or scalp.	Yes
38.	Are you stiff in the morning?	Yes
39.	Do you go to pieces easily and/or dislike working under pressure.	Yes
40.	Excessive menstrual bleeding.	Yes
41.	Migrating burning and/or tingling sensations (example: carpal tunnel syndrome).	Yes
42.	Do you have a history of significant exposure to chlorine, bromine and/or fluoride?	Yes
43.	Hoarseness for no particular reason.	Yes
44.	Chronic recurrent infections.	Yes
45.	Decreased sweating even with mild exercise.	Yes
46.	Frequent headaches especially migraines.	Yes
47.	Red face with exercise.	Yes
48.	Accelerated worsening of eyesight and/or hearing.	Yes
49.	Palpitations or uncomfortable noticeable heartbeat.	Yes
50.	Occasional difficulty in drawing a full breath.	Yes
51.	Mood swings, especially anxiety, panic and/or phobias.	Yes
52.	Gum problems.	Yes
53.	Excessive menopause symptoms, even with using estrogen.	Yes
54.	Skin problems of adult acne, eczema and/or severely dry.	Yes
55.	Do you have family members who have been diagnosed with thyroid problems?	Yes
56.	Increased cholesterol levels.	Yes
57.	Increased triglyceride levels.	Yes
58.	Do you eat soy products	Yes
59.	Do you eat uncooked or raw cruciferous vegetables? (cabbage, kale, brussel sprouts, broccoli, cauliflower)	Yes