Name **First Name** Date of birth Age

Phone number Mobile phone number Fax

E-Mail

Which physical complaints made you visit our practice?_____

_____

_____

_____

- **Questions about the thyroid gland:**

Is there a known illness of the thyroid?
no ☐ yes ☐, for _____ years
Enlargement ☐, Knot ☐,
Over-function ☐, Under-function ☐

Did you have a surgery on the thyroid gland ☐
or a radioiodine therapy? ☐
yes ☐, _____ months/years ago

Weight:
Did you lose weight?
no ☐ yes ☐, _____ kg in _____ months

Did you gain weight?
no ☐ yes ☐, _____ kg in _____ months

Do you have a racing heart? no ☐ yes ☐, strokes a minute _____
regularly ☐ irregular ☐

Do you have high blood pressure?
no ☐ yes ☐, lastly _____ mmHg

Do you have low blood pressure?
no ☐ yes ☐, lastly _____ mmHg

Do you have irregular bowel movement? no ☐ yes ☐, how many times a day? _____ Diarrhea ☐, Constipation ☐, Others ☐

Do you often have a feeling of obstruction in the throat?
no ☐ yes ☐

Do you suffer from …
…swallowing difficulties? no ☐ yes ☐
…shaking hands? no ☐ yes ☐
…hypersensitivity against heat? no ☐ yes ☐
…hypersensitivity against cold? no ☐ yes ☐

Are there any thyroid diseases known in your family?
no ☐ yes ☐
which ones?_____

- **Questions about bone metabolism/osteoporosis:**

Do you have…
…bone or joint pain? no ☐ yes ☐

…ever had a broken bone? no ☐
yes ☐, _____ months/years ago spine ☐, thigh ☐, forearm ☐,
others ☐ _____

Did you get diagnosed with low bone density?
no ☐ yes ☐, _____ months/years ago

Did you shrink? no ☐ yes ☐,
Pass height _____ cm, current height _____ cm

Was medication for osteoporosis prescribed to you?
no ☐ yes ☐ namely: _____
von _____ bis _____
Did you receive cortisone for more than 3 months?
no ☐ yes ☐, lastly _____
Do you suffer from…
…Kidney stone? no ☐ yes ☐
… Epilepsy? no ☐ yes ☐
Increased risk of falling?
no ☐ yes ☐, how many times last year? _____

Are there cases of osteoporosis in your family?
no ☐ yes ☐, who?_____

How often do you consume dairy products:
regularly ☐, a lot ☐, few ☐

Do you do sports?
regularly ☐, occasionally ☐, never ☐

Do you spend time in the sun?
a lot ☐, rarely ☐, never ☐
Do you smoke?
no ☐ yes ☐, _____ cigarettes a day, since _____ years
Did you smoke in the past?
no ☐ yes ☐, over _____ years
_____ cigarettes a day
Do you drink alcohol?
no ☐ occasionally ☐ regularly ☐, and how much?_____

- **General questions:**

Do you suffer from allergies? no ☐ yes ☐, namely _____
Were you diagnosed with one of the following illnesses?
Cancer ☐, when did it start? _____ Diabetes ☐, when did it start? _____
Heart diseases ☐, when did it start? _____ high cholesterol levels ☐, when did it start? _____
Other diseases ☐, which ones and when did it start? _____

Are there any hereditary diseases known? no ☐ yes ☐, which ones? _____
z. B. Osteoporosis? ☐ Type-2-diabetes ? ☐
Which kind of surgeries did you have? When?_____
_____
_____

Which medications to you take? (please quote how many mg/µg you take and how often you take your medications)

_____

_____

- **Questions for female patients:** ♀

When was the first day of your last period? _____

Is your period regularly ☐, irregular ☐,	Cycle duration less ☐ or more ☐ than 35 days?	
Do you have intermenstrual bleeding?	no ☐	yes ☐
Have you been diagnosed with ovarian cysts?	no ☐	yes ☐, since when? _____
Do you use a hormonal contraceptive?	no ☐	yes ☐, which one? _____
Do you have the desire to have children at the moment?	no ☐	yes ☐
Are you pregnant at the moment?	no ☐	yes ☐
Did you have diabeties in your pregnancy?	no ☐	yes ☐
Did you get an artificial insemination?	no ☐	yes ☐, when? _____
Did you ever have a miscarriage?	no ☐	yes ☐, when? _____, in the _____ week

How many pregnancie did you have? _____
How old are your kids? _____
How many months did you nurse your kids? _____ months

Did you have lactate?	no ☐	yes ☐, since _____ months

Do you suffer from…
… Hair loss ☐
… Hairiness ☐
… intensified acne ☐, since when? _____ months/years
… Hot flushes ☐
… increased mood swings ☐, since when? _____ months/years

Did you have episodes of…

…Anorexia?	no ☐	yes ☐, when? _____
…Bulimia?	no ☐	yes ☐, when? _____

Are you in your meno pause already?	no ☐	yes ☐, at the age of_____
Was it followed by a therapy with female hormones?	no ☐	yes ☐, over _____ years
Do you take in hormonal supplements at the moment?	no ☐	yes ☐, which ones? _____

- **Questions for male patients:** ♂

How many biological children do you have?_____
How old are the children? _____

Do you have any problems with the potency?	no ☐	yes ☐, yes _____ years
Were you diagnosed with a lack of male hormones?	no ☐	yes ☐, yes? _____
Do you suffer from breast growth?	no ☐	yes ☐, since when? _____

Do you experience lactation? no ☐ yes ☐, since when? _____