THYROID TRACKING SHEET

NAME: ____ **Date:** ______________

In the spaces provided please rate your current symptoms on the following scale:

0= No symptoms

1= Symptoms are Mild

2= Symptoms are Mild to Moderate

3= Symptoms are Moderate

4= Moderately Severe

5= Severe/ Frequent Symptoms

Question	Rating
Do you have fatigue?	_________
Do you have elevated cholesterol?	_________
Do you have difficulty losing weight?	_________
Do you have cold hands and feet?	_________
Are you sensitive to the cold?	_________
Do you have difficulty thinking or concentrating?	_________
	0
Do you experience brain fog or short term memory?	_________
	0
Are your moods depressed?	_________
Are you experiencing hair loss?	_________
Are you tired when you awaken?	_________
Do you have dry skin?	_________
	0
Do you have fluid retention?	_________
Do you have recurrent headaches?	_________
Do you sleep restlessly?	Yes or No
Do you have afternoon fatigue?	_________
Do you experience tingling or numbness in your hands or feet?	_________
Do you have decreased sweating?	_________
Have you had problems with infertility or miscarriages?	Yes or No
Do you have recurrent infections?	_________
Do your muscles ache?	_________
	0
Do you have thinning of your eyebrows or eyelashes?	_________
	0
Is your skin pasty, puffy or pale?	_________
	0
Is your voice hoarse?	_________
	0
Do you have low blood pressure?	_________
	0
Do you have sleep apnea?	_________

Current Medication Name & Strength: ____

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