

NUW Thyroid Assessment – Check ALL that apply

Name _____ Date: _____

<input type="checkbox"/> Dry hair or hair loss	<input type="checkbox"/> Autoimmune disease (Rheumatoid Arthritis, Lupus, Crohn's etc.)
<input type="checkbox"/> Constipation	<input type="checkbox"/> Reliance on coffee or other stimulants
<input type="checkbox"/> Heavy menstrual periods	<input type="checkbox"/> Low sex drive
<input type="checkbox"/> Milky discharge from breasts	<input type="checkbox"/> Lumps in breasts
<input type="checkbox"/> Joint aches and pains	<input type="checkbox"/> Gum problems
<input type="checkbox"/> Sweating less	<input type="checkbox"/> Anemia
<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Redness in face with exercise
<input type="checkbox"/> Hoarse voice	<input type="checkbox"/> Raynaud's syndrome (Pain and bluing of fingers with exposure to cold)
<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Tongue biting
<input type="checkbox"/> Tingling or numbness in fingers or feet	<input type="checkbox"/> Tendonitis/ tennis elbow
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Low endurance
<input type="checkbox"/> Hearing becomes worse	<input type="checkbox"/> Thick tongue
<input type="checkbox"/> Puffy eyes and face	<input type="checkbox"/> No energy for evening activities
<input type="checkbox"/> Slow heartbeat	<input type="checkbox"/> Throat clearing
<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Cracking in skin of heels
<input type="checkbox"/> Experiencing stiffness	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Weight gain of more than 5 lbs.	<input type="checkbox"/> Alopecia (patches of hair loss)
<input type="checkbox"/> Feeling more fatigued	<input type="checkbox"/> Premature graying of hair
<input type="checkbox"/> Skin becoming more coarse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dry eyes/ mouth	<input type="checkbox"/> Blocked arteries
<input type="checkbox"/> Baggy eyelids	<input type="checkbox"/> Polymyalgia
<input type="checkbox"/> Shortness of breath during mild exertion	<input type="checkbox"/> Vitiligo (loss of skin pigmentation)
<input type="checkbox"/> Slow speech and movement	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Low HDL
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Manic depression
<input type="checkbox"/> Decrease in memory	<input type="checkbox"/> Dyslexia
<input type="checkbox"/> Problems swallowing	<input type="checkbox"/> Inability to lose weight with diet and exercise
<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Attention deficit disorder
<input type="checkbox"/> Headaches and migraines	<input type="checkbox"/> Melasma (discoloration in face)
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Excess ear wax
<input type="checkbox"/> Exaggerated PMS/ menopause symptoms	<input type="checkbox"/> Oral temperature consistently below 98.5
<input type="checkbox"/> Yellow skin in palms	<input type="checkbox"/> Neck injury i.e. whiplash
<input type="checkbox"/> Scalloped tongue	<input type="checkbox"/> Ligament tears
<input type="checkbox"/> Increased cholesterol/ triglycerides/ LDL	<input type="checkbox"/> Family history of hypothyroidism or hyperthyroidism
<input type="checkbox"/> Cold hands/ feet	<input type="checkbox"/> Chronic infections
<input type="checkbox"/> Yeast infections	<input type="checkbox"/> Skin problems (hives, psoriasis, eczema)
<input type="checkbox"/> Loss of outside 1/3 of eyebrows	<input type="checkbox"/> Postpartum depression
<input type="checkbox"/> Depression/ anxiety	
<input type="checkbox"/> Swelling of hands and feet	
<input type="checkbox"/> Infertility	
<input type="checkbox"/> Slow thinking	
<input type="checkbox"/> Miscarriages	

Total checked out of 82: _____