

Endocrine Questionnaire

Name _____

Date _____

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints.
 Leave the question blank if it does not apply to you.
 0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

PART 1: Glandular Function

Section A:

- 1 Get dizzy when you stand up quickly 0 1 2 3
- 2 Lose your vision when you stand quickly 0 1 2 3
- 3 Weak and shaky often 0 1 2 3
- 4 Sensitive to bright light, sunlight or headlights 0 1 2 3
- 5 "Lump in throat" that hurts when upset 0 1 2 3
- 6 Headache when standing up 0 1 2 3
- 7 Crave salt 0 1 2 3
- 8 Heavy stress causes complete exhaustion 0 1 2 3
- 9 Easily startled or frightened 0 1 2 3
- 10 Loud noises cause your heart to pound 0 1 2 3
- 11 Form "goosebumps" easily 0 1 2 3
- 12 Dark circles under your eyes 0 1 2 3
- 13 Difficult time breathing 0 1 2 3
- 14 Are you a perfectionist? NO YES
(Press 0 for NO, 1 for YES)
- 15 Have allergies (hayfever, asthma, rashes, etc.) NO YES
(Press 0 for NO, 1 for YES)
- 16 Sensitive to environmental pollutants NO YES
(Press 0 for NO, 1 for YES)
- 17 Low blood pressure NO YES
(Press 0 for NO, 1 for YES)

Section B:

- 1 Experience chronic fatigue 0 1 2 3
- 2 Sensitive to cold weather 0 1 2 3
- 3 Easily depressed 0 1 2 3
- 4 Slow heartrate 0 1 2 3
- 5 Swollen eyes or face 0 1 2 3
- 6 Chronic constipation 0 1 2 3
- 7 Dry, flaky skin 0 1 2 3
- 8 Easily irritated 0 1 2 3
- 9 Slowed or slurred speech 0 1 2 3
- 10 Excess hair loss 0 1 2 3
- 11 Recurrent infections 0 1 2 3
- 12 Allergic reactions 0 1 2 3
- 13 Headaches 0 1 2 3
- 14 Heavy menstrual flow 0 1 2 3
- 15 Suffer from PMS 0 1 2 3
- 16 Low sex drive 0 1 2 3
- 17 Difficulty concentrating or remembering 0 1 2 3
- 18 Cry easily 0 1 2 3
- 19 Difficulty sleeping 0 1 2 3
- 20 Cold hands and feet 0 1 2 3

- 21 Shortness of breath 0 1 2 3
- 22 Forgetfulness 0 1 2 3
- 23 Gain weight easily NO YES
(Press 0 for NO, 1 for YES)
- 24 Hair and/or nails are brittle and dry NO YES
(Press 0 for NO, 1 for YES)
- 25 Painful periods (Press 0 for NO, 1 NO YES
for YES)
- 26 Axillary temperature below 97.5 F. NO YES
(Press 0 for NO, 1 for YES)
- 27 Increased cholesterol or triglycerides NO YES
(Press 0 for NO, 1 for YES)
- 28 Have you had miscarriages, stillbirths NO YES
or premature deliveries?
(Press 0 for NO, 1 for YES)

Section C:

- 1 Rapid heartbeat (>90 beats/minute) 0 1 2 3
- 2 Bulging, swollen eyes 0 1 2 3
- 3 Sweat excessively with moist skin and 0 1 2 3
palms
- 4 Increased appetite 0 1 2 3
- 5 Chest pains 0 1 2 3
- 6 Gastrointestinal disturbances 0 1 2 3
- 7 Difficult to relax 0 1 2 3
- 8 Insomnia 0 1 2 3
- 9 Menstrual problems 0 1 2 3
- 10 Rash or swelling in front of lower leg 0 1 2 3
- 11 Diarrhea 0 1 2 3
- 12 Enlarged thyroid (goiter) 0 1 2 3
- 13 Experience tremors (trembling) 0 1 2 3
- 14 Increased body temperature 0 1 2 3
- 15 Fatigue 0 1 2 3
- 16 Anxious and nervous 0 1 2 3
- 17 Low tolerance to heat 0 1 2 3
- 18 Lose weight easily NO YES
(Press 0 for NO, 1 for YES)

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Section D:

- 1 Feel better after eating 0 1 2 3
- 2 Fatigued if meal is missed 0 1 2 3
- 3 Hungry for sweets 0 1 2 3
- 4 Symptoms occur in afternoon or several hours after eating 0 1 2 3
- 5 Memory problems and/or poor concentration 0 1 2 3
- 6 Wake up at night feeling hungry 0 1 2 3
- 7 Digestive complaints 0 1 2 3
- 8 Headaches relieved by sweets or alcohol 0 1 2 3
- 9 Anxiety/nervousness 0 1 2 3
- 10 Rapid heartrate 0 1 2 3
- 11 Extreme hunger 0 1 2 3
- 12 Weak/shaky/jittery 0 1 2 3
- 13 Irritable if meal is missed 0 1 2 3
- 14 Dizziness when standing too quickly 0 1 2 3
- 15 Double vision 0 1 2 3

Section E:

- 1 Irritable 0 1 2 3
- 2 Frequent urination 0 1 2 3
- 3 Weakness or fatigue 0 1 2 3
- 4 Unusual hunger 0 1 2 3
- 5 Excessive thirst 0 1 2 3
- 6 Nausea/vomiting 0 1 2 3
- 7 Vision problems 0 1 2 3
- 8 Tingling/numbness in feet 0 1 2 3
- 9 Skin infections/leg sores 0 1 2 3
- 10 Cuts that will not heal (Press 0 for NO, 1 for YES) NO YES
- 11 History of diabetes in your family (Press 0 for NO, 1 for YES) NO YES
- 12 Overweight (Press 0 for NO, 1 for YES) NO YES

Section F:

- 1 Bloating of abdomen 0 1 2 3
- 2 Redness and bloating of face 0 1 2 3
- 3 Fatigue 0 1 2 3
- 4 Menstrual irregularities 0 1 2 3
- 5 Water retention/edema 0 1 2 3
- 6 Thyroid problems 0 1 2 3
- 7 Cold hands and feet 0 1 2 3
- 8 Cold all over 0 1 2 3
- 9 Sex drive reduced or lacking 0 1 2 3
- 10 Chronic headaches at level of eyes 0 1 2 3
- 11 Mental and/or emotional stress 0 1 2 3
- 12 Abnormal thirst 0 1 2 3

- 13 Excessive urination 0 1 2 3
- 14 Overweight at the hips/waist (pear-shaped) (Press 0 for NO, 1 for YES) NO YES
- 15 Lack of menstruation (Press 0 for NO, 1 for YES) NO YES
- 16 Slowed growth in children (Press 0 for NO, 1 for YES) NO YES
- 17 Infertility (Press 0 for NO, 1 for YES) NO YES

Section G:

- 1 Chronic swollen glands in neck/groin/armpit 0 1 2 3
- 2 Irregular heartbeat 0 1 2 3
- 3 Soreness in neck 0 1 2 3
- 4 Very susceptible to infections 0 1 2 3
- 5 Frequent flu-like symptoms 0 1 2 3
- 6 Infections last longer than 7 days (Press 0 for NO, 1 for YES) NO YES
- 7 Over the age of 50 (Press 0 for NO, 1 for YES) NO YES

Section H:

- 1 Symptoms worse in the evening 0 1 2 3
- 2 Difficulty waking in the morning 0 1 2 3
- 3 Irregular sleep habits 0 1 2 3
- 4 Symptoms worse in fall and/or winter 0 1 2 3
- 5 Lack of coordination in the dark (Press 0 for NO, 1 for YES) NO YES