Thyroid Eye Disease Pre-treatment Questionnaire

Name:_____
DOB: _____
Height:_____Weight:_____

Please place an X next to the symptoms you have and rate frequency and severity:

____ fatigue	daily	occasionally	mild	moderate	severe
____headache	daily	occasionally	mild	moderate	severe
____muscle spasms	daily	occasionally	mild	moderate	severe
____hair loss	daily	occasionally.	mild	moderate	severe
____brittle nails	daily	occasionally.	mild	moderate	severe
____anxiety	daily	occasionally.	mild	moderate	severe
____panic attacks	daily	occasionally.	mild	moderate	severe
____recent weight loss.	daily	occasionally.	mild	moderate	severe
____urinary tract infections	daily	occasionally.	mild	moderate	severe
____urinary incontinence	daily	occasionally.	mild	moderate	severe
____diarrhea	daily	occasionally.	mild	moderate	severe
____constipation	daily	occasionally.	mild	moderate	severe
____bloating	daily	occasionally.	mild	moderate	severe
____abdominal pain	daily	occasionally.	mild	moderate	severe

Please place an X if it applies to you:
____diabetes taking insulin
____diabetes on oral medications
____pre-diabetes

____inflammatory bowel disease (IBS)
____family history of IBS

____history of ear infections as a child
____hearing loss
____altered hearing such as ringing, buzzing or echo

For Childbearing Woman
This medication is not approved for woman who are pregnant or lactating
____ I am not pregnant or lactating
____ I am on effective birth control
____ I understand I will need to have a pregnancy test before each infusion

Patient Signature:_____Date:_____
Physician Signature:_____