BioLight TECHNOLOGIES

[Insert Address Here]
[Insert City, State and Zip Code Here]

TF (XXX) XXX-XXXX F (XXX) XXX-XXXX

Patient Name: ____ **Date:** __________________________________

Address: ____ **Date of Birth:** _____________________

City, State, Zip: ________________________________ **Home#:** ________________________________

Gender (circle one): **MALE** **FEMALE** **Work#:** _________________________________

Primary Care Physician: __________________________ **Referring Physician:** ________________

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you* ***eat, drink, rub on your skin, or inhale****.*
- *Our procedures are safe and painless.*

Thyroid Patient Condition Survey

[Please Check All Conditions You Experienced or Been Diagnosed with Medically]

1. Hypothyroidism YES NO
2. Hyperthyroidism YES NO
3. Grave's Disease YES NO
4. Hashimoto's Disease YES NO
5. Fibrocystic Breast Disease YES NO
6. Uterine Fibroids YES NO
7. Ovarian Fibroids YES NO

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8. Breast Disease	YES	NO
9. ADD	YES	NO
10. Vaginal Infections	YES	NO
11. Peyronie’s Disease	YES	NO
12. Migraine Headaches	YES	NO
13. Headaches	YES	NO
14. Fatigue	YES	NO
15. Dupuytren’s Contractures	YES	NO
16. Excess Mucous Formation	YES	NO
17. Hemorrhoids	YES	NO
18. Keloids	YES	NO
19. Parotid Diet Stones	YES	NO
20. Sebaceous Cysts	YES	NO

Hypothyroidism Risk/Symptoms Checklist

My risk factors for hypothyroidism include:

____ I have a family history of thyroid disease

____ I have had my thyroid "monitored" in the past to watch for changes

____ I had a previous diagnosis of goiters/nodules

____ I currently have a goiter

____ I was treated for hypothyroidism in the past

____ I had post-partum thyroiditis in the past

____ I had a temporary thyroiditis in the past

____ I have another autoimmune disease

____ I have had a baby in the past nine months

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____ I have a history of miscarriage

____ I have had part/all of my thyroid removed due to cancer

____ I have had part/all of my thyroid removed due to nodules

____ I have had part/all of my thyroid removed due to Graves' Disease/hyperthyroidism I have had radioactive iodine due to Graves' Disease/hyperthyroidism

____ I have had anti-thyroid drugs due to Graves' Disease/hyperthyroidism

I have the following symptoms of hypothyroidism, as detailed by the Merck Manual, the American Association of Clinical Endocrinologists, and the Thyroid Foundation of America .

____ I am gaining weight inappropriately

____ I'm unable to lose weight with diet/exercise

____ I am constipated, sometimes severely

____ I have hypothermia/low body temperature (I feel cold when others feel hot, I need extra sweaters, etc.)

____ I feel fatigued, exhausted

____ Feeling run down, sluggish, lethargic

____ My hair is coarse and dry, breaking, brittle, falling out

____ My skin is coarse, dry, scaly, and thick

____ I have a hoarse or gravely voice

____ I have puffiness and swelling around the eyes and face

____ I have pains, aches in joints, hands and feet

____ I have developed carpal-tunnel syndrome, or it's getting worse

____ I am having irregular menstrual cycles (longer, or heavier, or more frequent)

____ I am having trouble conceiving a baby

____ I feel depressed

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____ I feel restless

____ My moods change easily

____ I have feelings of worthlessness

____ I have difficulty concentrating

____ I have more feelings of sadness

____ I seem to be losing interest in normal daily activities

____ I'm more forgetful lately

Thyroid Patient Symptom Survey

[Please Check All Symptoms You Experience Even if Occassionally]

1. Weight Gain	YES	NO
2. Slower Heart Rate	YES	NO
3. Poor Memory	YES	NO
4. Muscle Weakness	YES	NO
5. Menstrual Irregularities	YES	NO
6. Infertility	YES	NO
7. Inability to Concentrate	YES	NO
8. Hoarseness	YES	NO
9. Fatigue	YES	NO
10. Essential Hypertension	YES	NO
11. Dry Skin	YES	NO
12. Depression	YES	NO
13. Cold Intolerance	YES	NO
14. Brittle Nails	YES	NO
15. Cold Hands & Feet	YES	NO
16. Constipation	YES	NO
17. Difficulty Swallowing	YES	NO
18. Elevated Cholesterol	YES	NO

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19. Eyelid Swelling	YES	NO
20. Hair Loss	YES	NO
21. Hypotension	YES	NO
22. Irritability	YES	NO
23. Muscle Cramps	YES	NO
24. Nervousness	YES	NO
25. Puffy Eyes	YES	NO
26. Throat Pain	YES	NO