

# Peirson Center for Children

2161 NE Broadway St.

Portland, OR 97232

(503) 209-9041

## Thyroid Questionnaire

Name: \_\_\_\_\_ dob: \_\_\_\_\_ date: \_\_\_\_\_

Please select all signs and symptoms that your child has experienced in the past (P) or currently (C).

- |                            |                            |  |                            |                            |   |                            |                            |   |
|----------------------------|----------------------------|--|----------------------------|----------------------------|---|----------------------------|----------------------------|---|
| <input type="checkbox"/> P | <input type="checkbox"/> C | <input type="checkbox"/> Depression                  | <input type="checkbox"/> P | <input type="checkbox"/> C | <input type="checkbox"/> Cold hands and feet        | <input type="checkbox"/> P | <input type="checkbox"/> C | <input type="checkbox"/> Fatigue  |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Dry skin                    | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Yellow or orange skin      | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Body Temp below 97.7°                                  |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Scalloped or large tongue   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Protruding tongue          | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Hoarse voice or cry                                    |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Puffiness around eyes       | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Broken/peeling fingernails | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Poor concentration/memory                              |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Mottled skin                | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Delayed tooth eruption     | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Fontanel closure after 2 yo                            |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Umbilical hernia            | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Swollen belly              | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Enlarged anterior fontanel                             |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Delayed growth              | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Constipation               | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Open posterior fontanel                                |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Difficulty swallowing       | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Slow speech                | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Bumps on back of upper arms                            |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Crossed eyes (strabismus)   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Nystagmus                  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Low iron levels  |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Sensitivity to loud noise   | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Reflux                     | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Low muscle tone  |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Coarse hair                 | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Thin hair                  | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Family history of hypothyroid                          |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Grinding teeth              | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Elevated triglycerides     | <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Elevated MCV despite B12<br>and folate supplementation |
| <input type="checkbox"/>   | <input type="checkbox"/>   | <input type="checkbox"/> Elevated or small platelets |                            |                            |   |                            |                            |   |

Select the teeth that your child currently has.

| Upper Teeth     |  | Erupt      | Shed       |
|-----------------|--|------------|------------|
| Central incisor |  | 8-12 mos.  | 6-7 yrs.   |
| Lateral incisor |  | 9-13 mos.  | 7-8 yrs.   |
| Canine (cuspid) |  | 16-22 mos. | 10-12 yrs. |
| First molar     |  | 13-19 mos. | 9-11 yrs.  |
| Second molar    |  | 25-33 mos. | 10-12 yrs. |

  

| Lower Teeth     |  | Erupt      | Shed       |
|-----------------|--|------------|------------|
| Second molar    |  | 23-31 mos. | 10-12 yrs. |
| First molar     |  | 14-18 mos. | 9-11 yrs.  |
| Canine (cuspid) |  | 17-23 mos. | 9-12 yrs.  |
| Lateral incisor |  | 10-16 mos. | 7-8 yrs.   |
| Central incisor |  | 6-10 mos.  | 6-7 yrs.   |