



Dr. Lipman's Thyroid Questionnaire

Check Yes or No next to each symptom. If you answer Yes to 6 or more in any section, or 15+ overall, you may need testing.

Metabolism & Energy Symptoms

- | | | |
|--|------------------------------|-----------------------------|
| 1. I feel tired even after sleeping. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I'm sensitive to cold temperatures. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I have frequent constipation. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. My skin is dry or rough. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. I have hair loss or thinning. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. My nails break easily. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. I've gained weight or can't lose it. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. My voice is hoarse or changed. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. I have puffiness around eyes or face. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. My pulse is slower than normal. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. I notice swelling in hands or feet. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. I have high cholesterol for no reason. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. I'm tired after light activity. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. My scalp is dry or itchy. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Outer third of eyebrows is thinning. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Mood, Brain & Cognitive Symptoms

- | | | |
|--|------------------------------|-----------------------------|
| 1. I feel depressed or low mood. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I can't focus or concentrate well. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I have poor memory or brain fog. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. I feel anxious without reason. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. I lack motivation. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. I get overwhelmed easily. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. I experience frequent brain fog. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. I feel mentally or physically slow. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. My reflexes or reactions are slow. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. I feel emotionally flat or numb. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. I cry easily or feel very sensitive. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. I struggle to find the right words. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. I withdraw from social events. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. I'm easily irritated. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. I've lost interest in hobbies. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Hormonal, Reproductive & General Symptoms

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| 1. My periods are heavy or irregular. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I've had trouble getting pregnant. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I have low libido. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. I have muscle or joint pain. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- 5. I retain water or feel bloated.
- 6. My skin looks pale or yellow.
- 7. I feel tingling in hands or feet.
- 8. My heart skips beats sometimes.
- 9. My throat feels tight or hoarse.
- 10. I've had miscarriages.
- 11. I've lost interest in intimacy.
- 12. My PMS or menopause symptoms are worse.
- 13. I notice neck swelling.
- 14. My body temperature is usually low.
- 15. I have family history of thyroid issues.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Scoring & Interpretation:

- Score for Section 1 (Metabolism): _____ Yes
- Score for Section 2 (Mood/Brain): _____ Yes
- Score for Section 3 (Hormonal): _____ Yes
- Total Yes Answers: _____

If 6 or more Yes in any section, or 15+ Yes in total — thyroid testing is recommended.