



THYROID HEALTH DETECTIVE TRACKING FORMS

A Companion Resource from the Book

These tracking forms are designed to help you organize important information about your thyroid health, including symptoms, laboratory results, medications, supplements, hormonal health, and changes over time. Use the forms that are most relevant to you and update them as needed. Keeping an organized record can help you recognize patterns, monitor your progress, and have more informed discussions with your healthcare providers.

DATE OF DIAGNOSIS

THYROID CONDITION

- ☐ Hypothyroidism ☐ Hashimoto's ☐ Hyperthyroidism
- ☐ Graves' Disease ☐ Thyroid Nodules ☐ Thyroid Cancer
- ☐ Thyroidectomy / Partial Thyroidectomy
- ☐ Other: _____

MAJOR LIFE EVENTS AROUND THAT TIME

Examples: significant stress, illness, surgery, pregnancy or postpartum changes, trauma, or major lifestyle changes.

INITIAL SYMPTOMS AT DIAGNOSIS

- ☐ Fatigue ☐ Weight changes ☐ Brain fog / difficulty concentrating
- ☐ Hair loss / thinning ☐ Anxiety ☐ Depression / low mood
- ☐ Cold intolerance ☐ Heat intolerance ☐ Sleep problems
- ☐ Constipation / digestive changes ☐ Muscle or joint discomfort
- ☐ Heart palpitations / heart-rate changes
- ☐ Menstrual / hormonal changes
- ☐ Other: _____

NOTES

[illegible]

LAB RESULTS & TREATMENT AT DIAGNOSIS

DATE OF LAB TEST: _____

THYROID PANEL

TEST	RESULT	REFERENCE RANGE
TSH		
Total T4		
Free T4		
Total T3		
Free T3		
Reverse T3, if tested		

THYROID ANTIBODIES

TEST	RESULT	REFERENCE RANGE
Thyroid Peroxidase Antibodies (TPOAb)		
Thyroglobulin Antibodies (TgAb)		

ADDITIONAL LABS

TREATMENT AT DIAGNOSIS

Medication(s): _____

Dose(s): _____

Time(s) Taken: _____

EARLY TREATMENT CHANGES

Record medication or dosage changes made during the first months after diagnosis.

[illegible]

SYMPTOM SNAPSHOT

Use this form to rate your symptoms at this point in time. Completing it periodically can help you recognize changes and patterns.

DATE: _____

0 = None | 1 = Very Mild | 2 = Mild | 3 = Moderate | 4 = Significant | 5 = Severe

ENERGY & METABOLISM

Fatigue	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Weight Changes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Cold Intolerance	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Heat Intolerance / Excessive Sweating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

BRAIN & MOOD

Brain Fog / Difficulty Concentrating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Mood Changes / Anxiety	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Depression / Low Mood	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PHYSICAL SYMPTOMS

Hair Loss / Thinning	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Dry Skin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep Problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Constipation / Digestive Changes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Muscle / Joint Discomfort	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Heart Palpitations / Heart-Rate Changes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Menstrual / Hormonal Changes (if applicable)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

OTHER SYMPTOMS / NOTES

THYROID LAB TRACKER

THYROID TEST	DATE 1	DATE 2	DATE 3	DATE 4
Date				
TSH				
Total T4				
Free T4				
Total T3				
Free T3				
Reverse T3				
TPOAb				
TgAb				
Other: _____				

THYROID MEDICATION / DOSE AT TIME OF TESTING

Date 1: _____

Date 2: _____

Date 3: _____

Date 4: _____

NOTES / CHANGES

MEDICATION TRACKER

MEDICATION	DOSE	TIME TAKEN	PURPOSE / REASON	START DATE

PRESCRIBING HEALTHCARE PROVIDER(S)

NOTES / CHANGES

TIP: Keep this form updated and bring it to your healthcare appointments. An accurate medication list helps your healthcare providers review your treatment and identify potential medication interactions.

SUPPLEMENTS & VITAMINS TRACKER

Use this form to maintain an up-to-date record of the vitamins, minerals, herbs, and other supplements you take, including dosage and timing.

SUPPLEMENT / VITAMIN	BRAND	DOSE	TIME TAKEN	PURPOSE / REASON

STARTED / STOPPED

RECOMMENDED BY

NOTES / CHANGES

TIP: Bring an updated supplement list to your healthcare appointments along with your medication list. Include vitamins, minerals, herbs, powders, and other supplements you use regularly or periodically.

HORMONAL HEALTH SUMMARY

Use this form to capture key information about your hormonal health. This can help you and your healthcare provider recognize patterns and changes over time.

CURRENT HORMONAL STATUS

Menstrual Cycle / Cycle Phase (if applicable):

Perimenopause / Menopause Status:

HORMONAL SYMPTOMS

Examples: hot flashes, night sweats, mood changes, irregular cycles, changes in libido, sleep changes, or other symptoms.

HORMONE THERAPY OR BIRTH CONTROL

PREGNANCY OR POSTPARTUM HISTORY (IF APPLICABLE)

OTHER HORMONAL CONDITIONS

Examples: PCOS, endometriosis, adrenal or pituitary conditions.

NOTES

HORMONE THERAPY TRACKER

Use this form to maintain an up-to-date record of hormone medications or therapies you are currently using.

HORMONE / THERAPY 1

Name: _____

Dose: _____ Start Date: _____

Form / Route: ☐ Oral ☐ Topical ☐ Patch ☐ Injection ☐ Other _____

Time Taken: _____

Purpose / Reason: _____

Prescribing Healthcare Provider: _____

HORMONE / THERAPY 2

Name: _____

Dose: _____ Start Date: _____

Form / Route: ☐ Oral ☐ Topical ☐ Patch ☐ Injection ☐ Other _____

Time Taken: _____

Purpose / Reason: _____

Prescribing Healthcare Provider: _____

HORMONE / THERAPY 3

Name: _____

Dose: _____ Start Date: _____

Form / Route: ☐ Oral ☐ Topical ☐ Patch ☐ Injection ☐ Other _____

Time Taken: _____

Purpose / Reason: _____

Prescribing Healthcare Provider: _____

NOTES

THYROID MEDICATION & SYMPTOM TRACKER

Use this form to record your thyroid medication and symptoms together. Tracking both over time can help you and your healthcare provider identify patterns and discuss changes in your treatment and how you are feeling.

DATE: _____

THYROID MEDICATION

Medication Name: _____

T4 Dose: _____ T3 Dose (if applicable): _____

Time(s) Taken: _____

Recent Dose or Medication Change: ☐ No ☐ Yes

If yes, describe: _____

HOW ARE YOU FEELING?

0 = None | 1 = Very Mild | 2 = Mild | 3 = Moderate | 4 = Significant | 5 = Severe

Fatigue ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Brain Fog / Difficulty Concentrating ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Sleep Problems ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Mood Changes / Anxiety ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Heart Palpitations / Heart-Rate Changes ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

ADDITIONAL INFORMATION

Weight (optional): _____

Resting Heart Rate (optional): _____

Other Symptoms / Changes: _____

NOTES

[illegible]

ADDITIONAL NOTES

DATE: _____

RELATED FORM / TOPIC: _____

[illegible]