AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094

Thyroid Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: _____ID/SSN: _____

Form No._____

Name of person treated: _____ Relationship to applicant: _____

1. Date of diagnosis or first symptoms:_____

2. Were you diagnosed with any of the following? Check all that apply.
   ☐ Hypothyroid (underactive) ☐ Nodule ☐ Hyperthyroid (overactive) ☐ Enlargement ☐ Goiter

3. Please give details on past treatment (diets, medication and length of time taken, surgeries and any other treatment): _____
   _____
   _____

4. Have you ever had surgery or been advised to have surgery for this condition? ☐ Yes ☐ No If yes, please provide details:
   _____
   _____
   _____

5. Are you currently taking any prescription medication for this condition? ☐ Yes ☐ No If yes, please list:
   Name of medication Amount taken per day How often per day
   _____
   _____
   _____
   If no, when was medication stopped and by whom? _____
   _____

6. Name and address of treating physician: _____
   _____

7. Date of last office visit with your physician:_____

8. Date of last thyroid blood test:_____ Was your thyroid testing within normal range? ☐ Yes ☐ No
   If no, what was the level?_____

9. Please list your current height:_____weight:_____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

_____ _____
Signature of person treated (or parent/guardian if under 18) Date