

# AIRMEN HYPOTHYROIDISM STATUS REPORT

Airman's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1) Control: Stable (Good-No changes recommended) \_\_\_\_\_ Adequate\_\_ \_\_\_\_\_ Poor \_\_\_\_\_

2) Treatment (List Medication with dosage): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3) In the past year, has the patient shown any signs or symptoms of fatigue, mental status impairment, or symptoms related to pulmonary, cardiac or visual systems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain and give details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4) Need one (1) TSH reading during the last year prior to FAA Exam:

\*Attach copy of test results

Date of test: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

(Please print)

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_