

PREGNANCY REFERENCE RANGE STUDY PARTICIPANT QUESTIONNAIRE

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Many thanks for agreeing to participate in this study. Please complete the following questionnaire as fully and honestly as possible:

Date today:

Date of birth:

Estimated Due Date:

Pre-pregnancy weight:

Current weight:

Ethnicity:

Height:

Are you having twins/multiple birth? Yes / No

Do you have or have ever had the following thyroid problems:

Overactive Thyroid (hyperthyroidism)	Yes	No
Underactive Thyroid (hypothyroidism)	Yes	No
Thyroid nodule	Yes	No
Radioactive Iodine	Yes	No

Are you currently taking, or have previously taken:

Levothyroxine	Yes	No
Tri-iodothyronine (T3)	Yes	No
Armour Thyroid	Yes	No
Carbimazole	Yes	No
Propylthiouracil (PTU)	Yes	No

Do you have or have ever had raised blood pressure? Yes / No

Are you on blood pressure medications at the moment? Yes / No

If so, please list:

Are you on any other medications? If so please list: