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Acromegaly Examination
Comprehensive Version

Name: _____ SSN: _____

Date of Exam: _____ C-number: _____

Place of Exam: _____

A. Review of Medical Records:

B. Medical History (Subjective Complaints):

Comment on:

1. Date diagnosis established.
2. History of surgery or hospitalizations for acromegaly. If acromegaly is due to a neoplasm, report exact type, location, and types and dates of treatment.
3. Joint pains.
4. Changes in vision.
5. Headaches (severity and frequency).
6. Cardiac symptoms.
7. Change in shoe, glove, or hat size.
8. Symptoms of glucose intolerance.
9. Other complaints: voice changes; paresthesias; fatigue; depression; muscle weakness; enlarged jaw, lips, nose, tongue; skin changes; in men, erectile dysfunction; in women, breast discharge or menstrual cycle abnormalities.
10. History of colon polyps.
11. Treatment other than for neoplasm.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings:

1. Vital signs, blood pressure X3, percent of weight gained or lost compared to baseline (average weight in the 2 years preceding onset of disease).
2. Acromegalic facial or skin abnormalities.
3. Arthropathy.
4. Cardiac or pulmonary abnormalities, including signs of congestive heart failure. Heart size and how determined.
5. Evidence of increased intracranial pressure.
6. Enlargement of acral parts or long bones.

7. Visual impairment, including visual fields.
8. Other: hirsutism in women, macroglossia, peripheral neuropathy, evidence of sleep apnea.

D. Diagnostic and Clinical Tests:

Provide, as indicated:

1. Imaging study of brain or sella turcica.
2. Glucose tolerance test.
3. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

Comment on: Is the disease active or in remission?

Signature:

Date: