

Acromunity Medical Details and Treatment Tracker

This document is intended to help you keep a record of important details that you may need to share with healthcare professionals throughout your journey living with acromegaly, particularly when you are first diagnosed. Take a copy with you to your various appointments and ask your healthcare professionals to help you complete it.

About You	
Write down your name and contact details here and the name and phone number of someone to contact in an emergency such as a family member or close friend.	
First Name:	
Last Name:	
Date of Birth:	
Phone:	
Email:	
Emergency Contact: (Name/Phone Number)	
Notes	

Your Acromegaly History

Make a note of your acromegaly history here, such as the date you were first diagnose and who made the diagnosis, and any symptoms you were experiencing. Ask your healthcare team to help you fill in this section if needed.

Date of Your Diagnosis (day, month, year):	
Who Made the Diagnosis?	<input type="checkbox"/> Primary care doctor <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Other
What were (are) your symptoms:	
Other information about your acromegaly:	

Your Tests and Results

Keep a record of any tests or procedures that you may have had here. Ask a member of your healthcare team to help you complete this section and to keep it updated.

Date of test	Test name (e.g. MRI scan. IGF-1 blood test)	Result of test

Your Treatment Plan

Ask a member of your healthcare team to help you complete this section and make a note of the treatments you have or will receive.

Treatment Goal:	
Treatments Received:	
Surgery	Date of surgery: Type of surgery: Location of surgery: Outcome of surgery:
Radiation Therapy	Type of radiation therapy: Dose and radiation schedule: Date of first treatment: Date of last treatment: Outcome of radiation therapy:
Medication	Name of medication: Dose and frequency: Date of first treatment: Date of last treatment: Outcome of medical therapy:
Other treatments received for acromegaly:	

Your Healthcare Professionals

Write down the names and contact details of the healthcare professionals in your multidisciplinary team here, such as the name of your primary care doctor and nurse, endocrinologist and others who are involved in your care.

Primary care doctor

Name:

Practice address:

Telephone:

Email:

Endocrinologist

Doctor's name:

Clinic or hospital address:

Telephone:

Email:

Neurosurgeon:

Doctor's name:

Clinic or hospital address:

Telephone:

Email:

Endocrine nurse

Name:

Clinic or hospital address:

Telephone:

Email:

Other

Name:

Clinic or hospital address:

Telephone:

Email:	
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Your General Health			
<p>Make a note of your general health and any other specific health issues here, such as if you are allergic to a particular medication or have been diagnosed with other medical conditions such as high blood pressure, high cholesterol, asthma or diabetes.</p>			
Do you have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Describe any allergies you may have here (e.g., allergic to penicillin)	<p>.....</p> <p>.....</p> <p>.....</p>		
Other than acromegaly, do you have any other long-term medical conditions for which you receive treatment?	<input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Heart disease <input type="checkbox"/> Irritable bowel syndrome (IBS) or inflammatory bowel disease (e.g. ulcerative colitis, Crohn's disease) <input type="checkbox"/> Other, please specify..... <p>.....</p>		
List any medications you may be taking here	<p>Name of medication.....</p> <p>Reason.....</p> <p>Dose and frequency.....</p> <p>Name of medication.....</p> <p>Reason.....</p> <p>Dose and frequency.....</p>		

	Name of medication..... Reason..... Dose and frequency.....
How tall are you?	[] meters and [] cm <i>or</i> [] Feet [] inches
What is your current weight?	[] Kg or [] stones and [] pounds
Other (list any other information you think might be important here):	

Your Notes

Make any additional notes here, such as any questions you would like to ask at your next appointment or any concerns that you may have regarding living with acromegaly.

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