Acromegaly Symptoms Tracker

Caring for acromegaly involves so much more than blood work. Communicating how acromegaly affects your quality of life may be challenging, but this information is important for your health care team to ensure they are addressing all aspects of your disease.

This symptom tracker may be a useful way to document your symptoms and serve as a reference at your next appointment. This is a tool to help you to prepare for your next appointment and is not intended to serve as medical advice. If at any time you experience severe symptoms, immediately contact your physician.

To use this tracker, circle "**Yes**" or "**No**" to indicate whether or not you experienced a symptom that day.

Circle a number between **1-5**, to log the impact that each symptom that you experience has on your daily activities.

- 1 – No impact (mild)
- 3 – I need some help (moderate)
- 5 – I am unable to function (severe)

Include any medications used to alleviate your symptoms.

If you are not receiving injections of long-acting medication to control your acromegaly, you may still use this tracker, however, if you are, start tracking symptoms on the day immediately following your injection. That is the first day of:

Week 1. Date of SSA Injection: ________________________

HEADACHES

Are you experience headaches today? **Yes** or **no**?

On a scale of 1-5, how much do they impact your daily activities?

- 1 – No impact
- 3 – I need some help
- 5 – I am unable to function

*Circle one number per day using the scale of **1-5** to describe your level of discomfort.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
(severity)	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5
Week 2	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
(severity)	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5
Week 3	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
(severity)	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5
Week 4	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
(severity)	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5
Week 5	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No	Yes | No
(severity)	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5	1 | 2 | 3 | 4 | 5

During this time are you taking any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

SWELLING

Do you experience swelling today? **Yes** or **no**?

On a scale of 1-5, how severe is the swelling?

- 1 – Mild
- 3 – Moderate
- 5 – Extreme

*Circle one number per day using the scale of **1-5** to describe your level of swelling.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 2	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 3	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 4	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 5	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Where do you noticed swelling during this time (circle all that apply):

hands, **feet, face,** (**other** ______________________).

During this time are you taking any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

Sleep Quality

After you sleep for a full night do you still feel tired? **Yes** or **No**?

On a scale of 1-5 how tired are you?

- 1 – Not tired
- 2 – A little tired
- 3 – Very tired

*Circle one number per day using the scale of **1-5** to describe your level of tiredness.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(tiredness)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 2	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(tiredness)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 3	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(tiredness)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 4	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(tiredness)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 5	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(tiredness)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

During this time are you taking any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

BODY ACHES

Does your body ache in places that are not related to physical activity? **Yes** or **No**?

On a scale of 1-5, how much do they impact your daily activities?

- 1 – Mild
- 3 – Moderate
- 5 – Severe

Circle one number per day using the scale of ***1-5*** *to describe your level of discomfort.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 2	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 3	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 4	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 5	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Where do you noticed aching during this time? ____.

During this time have you taken any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

JOINT PAIN

Do you experience joint pain? **Yes** or **No**?

On a scale of 1-5, how severe is your joint pain?

- 1 – Mild
- 3 – Moderate
- 5 – Severe

*Circle one number per day using the scale of **1-5** to describe your level of discomfort.*

<table>
<tr><th>Joint Pain</th><th colspan="5">Monday</th><th colspan="5">Tuesday</th><th colspan="5">Wednesday</th><th colspan="5">Thursday</th><th colspan="5">Friday</th><th colspan="5">Saturday</th><th colspan="5">Sunday</th></tr>
<tr><td>Week 1</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td></tr>
<tr><td>(severity)</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td>Week 2</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td></tr>
<tr><td>(severity)</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td>Week 3</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td></tr>
<tr><td>(severity)</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td>Week 4</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td></tr>
<tr><td>(severity)</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td>Week 5</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td><td colspan="2">Yes</td><td colspan="3">No</td></tr>
<tr><td>(severity)</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
</table>

During this time have you taken any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

SWEATING

Have you been sweating excessively? **Yes** or **No**?

On a scale of 1-5 how severe is your sweating?

- 1 – Mild
- 3 – Moderate
- 5 – Excessive

*Circle one number per day using the scale of **1-5** to describe your level of sweating.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 2	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 3	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 4	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 5	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(severity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

During this time have you taken any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

SNORING

Are you snoring? **Yes** or **No**?

On a scale of 1-5 how did your snoring impact your quality of sleep?

- 1 – More than one waking
- 3 – Waking up more than once
- 5 – Waking up more than once and difficulty falling asleep between wakings

*Circle one number per day using the scale of **1-5** to describe your quality of sleep.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(intensity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 2	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(intensity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 3	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(intensity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 4	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(intensity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Week 5	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
(intensity)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

During this time have you taken any medication to alleviate this specific symptom?

Yes/No

If **yes**, which medicine? ____.

OTHER

*Fill in your symptom and circle **yes** or **no** for each week since your previous appointment.*

Symptom	Week 1	Week 2	Week 3	Week 4	Week 5
______________	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
______________	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
______________	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
______________	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
______________	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

During this time have you taken any medication to alleviate a specific symptom? **Yes**/**No**?

If **yes**, which symptom and which medication(s)?

____

____