



## Acromegaly Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M/F

Tobacco Usage: \_\_\_\_\_ Face Amount: \_\_\_\_\_

\_\_\_Term 10 15 20 30                      \_\_\_UL

1. When was the proposed insured diagnosed with Acromegaly?

2. Does the proposed insured experience any of the following symptoms? (Check all that apply)

\_\_\_Joint pain    \_\_\_Enlarged heart    \_\_\_Arthritis    \_\_\_Enlargement of other organs    \_\_\_Fatigue  
\_\_\_Headaches    \_\_\_Loss of vision    \_\_\_Weakness in arms/legs

3. What treatment has the proposed insured received for this condition:

\_\_\_\_\_  
\_\_\_\_\_

a. Surgery Details: \_\_\_\_\_  
\_\_\_\_\_

b. Radiation Therapy Details: \_\_\_\_\_  
\_\_\_\_\_

c. Injection of a growth hormone blocking drug Details: \_\_\_\_\_  
\_\_\_\_\_

4. Please provide name, dosage and frequency of all medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Does the proposed insured have any other health conditions for which they receive ongoing treatment? (If yes, please provide details)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_