SYMPTOMS LIST (F01)

Chronic Kidney Disease in Children (CKiD)

SECTION A: GENERAL INFORMATION

A1. PARTICIPANT ID: AFFIX ID LABEL OR ENTER NUMBER IF ID LABEL IS NOT AVAILABLE

|__|- |__|__| - |__|__|__|

A2. CKiD STUDY VISIT #: 0 1 a

A3. FORM VERSION: 0 1 / 0 1 / 0 5

A4. DATE OF VISIT: ___ ___/ ___ ___/ ___ ___ ___ ___
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A5. INDICATE PERSON COMPLETING THE FORM
Child..... 1
Parent or other adult..... 2
Both (Parent and Child)... 3

Instructions: Thinking back on the ***last month***, indicate the number of days in which your child has felt each of the symptoms listed below. If you/your child has never felt the symptom, then enter a "0" (zero) in the space. ***Do not leave the space blank***. If you/your child enter a "1" or number greater than 1, then ***circle the number*** under the column that best describes the severity of each of the symptom that was felt. Leave "severity" blank if the symptom was not felt.

Symptoms	**Number of days in past month** *(Enter 0 if none.)*	**Severity**		
		Mild Symptoms did not interfere with usual activities	**Moderate** Symptoms interfered somewhat with usual activities	**Severe** Symptoms were so bothersome that usual activities could not be performed
1. Nausea or being sick to your stomach?	___ ___	1	2	3
2. Vomiting?	___ ___	1	2	3
3. Diarrhea?	___ ___	1	2	3
4. Constipation?	___ ___	1	2	3
5. Itching?	___ ___	1	2	3
6. Numbness and tingling in your hands and feet?	___ ___	1	2	3
7. Feeling faint when you stand up?	___ ___	1	2	3
8. Blurred vision?	___ ___	1	2	3
9. Problems urinating (urgency, frequency, burning)?	___ ___	1	2	3
10. Headaches?	___ ___	1	2	3
11. A bad taste in your mouth?	___ ___	1	2	3
12. Loss of appetite?	___ ___	1	2	3

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		Mild Symptoms did not interfere with usual activities	**Moderate** Symptoms interfered somewhat with usual activities	**Severe** Symptoms were so bothersome that usual activities could not be
13. Increased appetite?	___ ___	1	2	3
14. Weight increase?	___ ___	1	2	3
15. Heartburn?	___ ___	1	2	3
16. Abdominal bloating or gas?	___ ___	1	2	3
17. Abdominal pain?	___ ___	1	2	3
18. Swelling (excess fluid)?	___ ___	1	2	3
19. Hiccoughs?	___ ___	1	2	3
20. Hives or another type of rash?	___ ___	1	2	3
21. Easy bruising or bleeding?	___ ___	1	2	3
22. Tiring easily, weakness?	___ ___	1	2	3
23. Muscle cramps? (Exclude menstrual cramps)	___ ___	1	2	3
24. Waking up too early in the morning?	___ ___	1	2	3
25. Falling asleep during the day?	___ ___	1	2	3
26. Feeling irritable?	___ ___	1	2	3
27. Decreased alertness?	___ ___	1	2	3
28. Leg pain?	___ ___	1	2	3
29. Flank pain (kidney pain)?	___ ___	1	2	3
30. Other unexpected symptoms? ***Specify:*** _____	___ ___	1	2	3

TO BE COMPLETED BY CLINICAL SITE:

DATE: ___ ___/ ___ ___/ ___ ___ ___ ___
M M / D D / Y Y Y Y

INITIALS: ___ ___ ___