

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

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A2. CKiD STUDY VISIT #:

__ __

A3. FORM VERSION:

0 1 / 0 1 / 0 6b

A4. DATE OF VISIT:

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

A5. INDICATE PERSON COMPLETING THE FORM

Child/young adult..... 1
Parent or other adult..... 2
Both (Parent and Child/young adult) 3

A6. Is this study visit an irregular (accelerated) visit?

Yes..... 1
No..... 2

Instructions: Thinking back on the **last month**, indicate the number of days in which your child (or you, if child/young adult participant is completing the form) 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 upset 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 hands and/or feet?	__ __	1	2	3
7. Feeling faint when standing 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 mouth?	__ __	1	2	3

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12. Loss of appetite?	___ ___	1	2	3
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? <i>Specify:</i> _____	___ ___	1	2	3

TO BE COMPLETED BY CLINICAL SITE:

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

INITIALS: _____

ADMINISTRATION: 1 = Interviewer Assisted
(Circle "1", "2" or "3") 2 = Self-Administered
 3 = Both