Attention - DO NOT enter patient data on this form if the header does not contain *preprinted* HALT PKD ID number, clinical center ID, and visit number.

Participant ID: _____ *haltid* **Clinical Center:** _____ *clinic* **Date of Visit:** ____/____/____
month *dvm* day *dvd* year *dvy*

visit:

___Form was not completed *misfm*

SYMPTOMS CHECKLIST

Form # 5

Please complete this form before your physical exam, then discuss your answers with designated personnel.

1. Check "yes" or "no" for symptoms experienced since your last visit (or within the past month if this is your first visit). Feel free to comment in the column marked "specify/describe."

Symptoms	Yes	No	Specify/Describe if applicable
	1	0	
CONSTITUTIONAL			
Malaise/Feeling sickly or ill *illyn*			*illdes*
HEAD/NECK			
Headache *headyn*			*headdes*
Blurred Vision/Visual Changes *visnyn*			*visndes*
Dry Eyes/Nasal Passages *eyeyn*			*eyedes*
Nasal Congestion *noseyn*			*nosedes*
Sore Throat *thrtyn*			*thrtdes*
Dry Mouth/Excessive Thirst *mthyn*			*mthdes*
CARDIOVASCULAR			
Chest Pain *chstyn*			*chstdes*
Heart Palpitations *hrtyn*			*hrtdes*
Dizziness/Lightheadedness *dizyn*			*dizdes*
Fatigue/Weakness *ftgyn*			*ftgdes*
Leg Swelling/Edema *legyn*			*legdes*
RESPIRATORY			
Shortness of Breath with Exertion *btheyn*			*bthedes*
Shortness of Breath at Rest *brhryn*			*brhrdes*
Cough *cghyn*			*cghdes*
MUSCULOSKELETAL			
Joint Pain/Aches *jntpn*			*jntpndes*
Muscle Pain/Cramping/Spasm *muspn*			*muspndes*
GENITOURINARY			
Kidney Pain (Back or Flank Pain) *kidpn*			Left/Right/Bilateral Mild/Moderate/Severe *kidpndes*
Urinary Changes *urinc*			*urincdes*
Blood in Urine *bldur*			*bldurdes*
Impotence/Decreased Libido *impot*			*impotdes*
Urinary Tract Infection *uti*			*utides*
Kidney Stone *kidst*			*kidstdes*
DERMATOLOGIC			
Changes of the Skin or Hair *sknc*			*skncdes*

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month *dvm* day *dvd* year *dvy*

visit:

___Form was not completed *misfm*

SYMPTOMS CHECKLIST

Form # 5

Symptoms			Specify/Describe if applicable
GASTROINTESTINAL	**Yes**	**No**	
	1	**0**	
Nausea/Vomiting *naus*			*nausdes*
Diarrhea *diarh*			*diarhdes*
Constipation *const*			*constdes*
Stomach Discomfort/Abdominal Pain *abdpn*			*abdpndes*
Liver Cyst Pain *livcy*			Mild/Moderate/Severe *livcydes*
Changes in Appetite *appc*			*appcdes*
NEUROLOGICAL			
Mood Changes like Anxiety, Restlessness, Depression *moodc*			*moodcdes*
Tingling/ Numbness *numb*			*numbdes*
Problems with Memory *mempr*			*memprdes*
Drowsiness *drowsy*			*drowsydes*
Insomnia/Problems Sleeping *insom*			*insomdes*
Other Symptoms	**Yes**	**No**	**Specify/Describe if applicable**
	1	**0**	
osym1/osym1yn			*osym1des*
osym2/osym2yn			*osym2des*
osym3/osym3yn			*osym3des*
osym4/osym4yn			*osym4des*
osym5/osym5yn			*osym5des*
osym6/osym6yn			*osym6des*
osym7/osym7yn			*osym7des*
osym8/osym8yn			*osym8des*
osym9/osym9yn			*osym9des*
osym10/osym10yn			*osym10des*

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month *dvm* day *dvd* year *dvy*

visit:

___Form was not completed *misfm*

SYMPTOMS CHECKLIST

Form # 5

2.	**Have you seen a doctor since your last visit?** (In the past month if this is your first visit) *docvis*	1 ☐ **Yes** 0 ☐ **No**
3.	**Have you visited an emergency room since your last visit?** (In the past month if this is your first visit) *ervis*	1 ☐ **Yes** 0 ☐ **No**
4.	**Have you been hospitalized since your last study visit?** (In the past month if this is your first visit) *hosvis*	1 ☐ **Yes** 0 ☐ **No**
5.	**Since your last visit have you had any of the following procedures performed:** *lvproc*	1 ☐ **Yes** 0 ☐ **No**
	If Yes, what type of procedure?	
	Kidney cyst aspiration, drainage *kidcy*	1 ☐ **Yes** 0 ☐ **No**
	Liver cyst aspiration, drainage *livcyas*	1 ☐ **Yes** 0 ☐ **No**
	Lithotripsy to break up a kidney stone or stone retrieval via scope *litho*	1 ☐ **Yes** 0 ☐ **No**
	Other, *othr* **Please describe** _____ *othdes*	1 ☐ **Yes** 0 ☐ **No**
6.	**Since your last visit, how many days did you feel you accomplished (at home, at work) less than you would have liked to because of complications of PKD? #** _____ days *unpro*	
7.	**Women of child bearing potential only** *naprem*	1 ☐ **N/A**
	Since your last study visit (or in the past six months if this is your first visit)	
	a.) Have there been any changes in your method of birth control? *bcchg*	1 ☐ **Yes** 0 ☐ **No**
	b.) Have you become pregnant since your last study visit? *pregn*	1 ☐ **Yes** 0 ☐ **No**
	c.) Have you had a change in menstruation or missed a period since your last visit? *misper*	1 ☐ **Yes** 0 ☐ **No**
	d.) Are you currently pregnant? *curpreg*	1 ☐ **Yes** 0 ☐ **No**
	If applicable, when did the pregnancy end?	__ __/__ __/ __ __ __ __ *curpregm/curpregd/curpregy*
	e.) Are you currently breastfeeding? *curbfeed*	1 ☐ **Yes** 0 ☐ **No**
	If applicable, when did you stop breastfeeding:	__ __/__ __/ __ __ __ __ *cbfeedm/cbfeedd/cbfeedy*
	f.) Pregnancy outcome *pregoc* __ __/__ __/__ __ __ __ *pregocm/pregocd/pregocy*	0 ☐ **N/A** 1 ☐ **Live Birth** 2 ☐ **Still Birth** 3 ☐ **Spontaneous abortion** 4 ☐ **Therapeutic abortion**

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___Form was not completed *misfm*

SYMPTOMS CHECKLIST

Form # 5

8. Designated Personnel to Complete This Section:

a.) Are any of the symptoms/events reported unanticipated: 1 ☐ **Yes** 0 ☐ **No**
(If Yes, comment below) *symuna*

Note: Your IRB may require additional reporting of unexpected non-serious adverse events.

b.) Do any symptoms/events reported require a dose modification?
(If Yes, enter on drug form) *symdm* 1 ☐ **Yes** 0 ☐ **No**

c.) Do any symptoms/events reported require an SAE report ?
(i.e., #4 above. If yes, enter Form 13) *symsae* 1 ☐ **Yes** 0 ☐ **No**

d.) Do any symptoms/events reported require an unmasking of study medication ?
(If Yes, enter Form 26) *symunm* 1 ☐ **Yes** 0 ☐ **No**

e,) Are antihypertensives taken for any non-BP symptoms/conditions?
(If Yes, enter drugs on form 6) *symnbpm* 1 ☐ **Yes** 0 ☐ **No**

Comment: *cmmnt*

_____

_____

_____

_____

****

HALT PKD staff member completing this form: _____ **Date:** __ __/__ __/__ __ __ __
cmidnum Month *cdm* Day *cdd* Year *cdy*

Data Entry Status: Please check to indicate that the above information has been entered ☐

Primary Entered by: _____ Date: __ __/__ __/__ __ __
deidnum *dem* Month *ded* Day *dey* Year

Secondary Entered by: _____ Date __ __/__ __/__ __ __ __