Modification of Diet in Renal Disease Study
PATIENT SYMPTOM FORM

This form should be completed by the patient at each monthly visit. The study coordinator should complete items 1-4 and 101-104 as usual. For stop point patients it should be completed annually.

In Datalex, Severity is entered using a coding scheme. If mild is checked, enter a 1 in the space provided on the Datalex screen. If moderate is checked, enter a 2. If severe is checked, enter a 3. These instructions are provided only on the 2nd screen of the Datalex application.

The number of days in past month should be from 0-31. Not since the last visit.

For DCC Use Only
Rev. 1 9/1/88

E ___
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MDRD

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Patient Symptom Form

Thinking back on the last month, mark the number of days in which you have felt each of the symptoms listed below. If you never felt the symptom then enter a zero in the space. Do not leave it blank. Next, put a check under the column indicating the severity of each of the symptoms that was felt. Leave severity blank if symptom not felt.

FORM # 2 6

1. Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center ..... ___ ___
4. a. Date of visit ..... ___ ___/___ ___/___ ___
   b. Visit Type ..... ___
   c. Visit Number ..... ___ ___ . ___

	Number of Days in Past Month (Enter 0 if None)	SEVERITY		
		Mild	Moderate	Severe
5. a bad taste in your mouth?	___ ___	___	___	___
6. loss of appetite?	___ ___	___	___	___
7. nausea or being sick to your stomach?	___ ___	___	___	___
8. vomiting?	___ ___	___	___	___
9. heartburn?	___ ___	___	___	___
10. abdominal bloating or gas?	___ ___	___	___	___
11. diarrhea?	___ ___	___	___	___
12. constipation?	___ ___	___	___	___
13. hiccoughs?	___ ___	___	___	___
14. itching?	___ ___	___	___	___
15. hives or another type of rash?	___ ___	___	___	___
16. easy bruising or bleeding?	___ ___	___	___	___
17. lack of pep and energy?	___ ___	___	___	___

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	Number of Days in Past Month (Enter 0 if None)	SEVERITY		
		Mild	Moderate	Severe
18. tiring easily, weakness?	___ ___	___	___	___
19. muscle cramps?	___ ___	___	___	___
20. numbness and tingling in your hands and feet?	___ ___	___	___	___
21. feeling faint when you stand up?	___ ___	___	___	___
22. difficulty in falling or staying asleep?	___ ___	___	___	___
23. falling asleep during the day?	___ ___	___	___	___
24. feeling irritable?	___ ___	___	___	___
25. decreased alertness?	___ ___	___	___	___
26. forgetfulness?	___ ___	___	___	___
27. blurred vision?	___ ___	___	___	___
28. Other unexpected symptoms?	___ ___	___	___	___
(20 characters maximum)(_____)				

101. Date this form completed by patient ..... ___ ___/___ ___/___ ___

102. Certification number of person reviewing this form ..... ___ ___ ___ ___ ___

103. Date form entered ..... ___ ___/___ ___/___ ___

104. Certification number of data entry person ..... ___ ___ ___ ___ ___

Retain a copy of this form for your files. Send the original to the MDRD Study Data Coordinating Center. Please use MDRD Study mailing labels:

MDRD Study Data Coordinating Center
Department of Biostatistics & Epidemiology
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44195-5196