# Symptoms List

Chronic Kidney Disease in Children (CKID)

Data entry person:

_____

## SECTION A: GENERAL INFORMATION

CKiD Visit #

_____

A3. FORM VERSION: 01/01/06b

_____

A4. DATE OF VISIT:

_____

A5. INDICATE PERSON COMPLETING THE FORM

◯ Child/young adult
◯ Parent or other adult
◯ Both (Parent and Child/young adult)

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

◯ Yes
◯ No

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 please select 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

Severity
Mild

Moderate

Severe

(Enter 0 if none)

Symptoms did not interfere with usual activities

Symptoms interfered somewhat with usual activites

Symptoms were so bothersome that usual activities could not be performed

1. Nausea or upset stomach? _____ _____
2. Vomiting? _____ _____

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3. Diarrhea? _____ _____
4. Constipation? _____ _____
5. Itching? _____ _____
6. Numbness and tingling in hands and/or feet? _____ _____
7. Feeling faint when standing up? _____ _____
8. Blurred vision? _____ _____
9. Problems urinating (urgency, frequency, burning)? _____ _____
10. Headaches? _____ _____
11. A bad taste in mouth? _____ _____
12. Loss of appetite? _____ _____
13. Increased appetite? _____ _____
14. Weight increase? _____ _____
15. Heartburn? _____ _____
16. Abdominal bloating or gas? _____ _____
17. Abdominal pain? _____ _____
18. Swelling (excess fluid)? _____ _____
19. Hiccoughs? _____ _____
20. Hives or another type of rash? _____ _____
21. Easy bruising or bleeding? _____ _____
22. Tiring easily, weakness? _____ _____
23. Muscle cramps? (Exclude menstrual cramps) _____ _____
24. Waking up too early in the morning? _____ _____
25. Falling asleep during the day? _____ _____
26. Feeling irritable? _____ _____
27. Decreased alertness? _____ _____
28. Leg pain? _____ _____
29. Flank pain (kidney pain)? _____ _____
30. Other unexpected symptoms? _____ _____
_____

DATE: _____

INITIALS: _____

ADMINISTRATION:
◯ 1= Interviewer Assisted
◯ 2= Self-Administered
◯ 3= Both

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