

**Kidney Care Clinic:  
Clinic Visit Form for Patients with  
ADPKD**

Rev: November 2019

**PATIENT INFORMATION LABEL**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

PHN: \_\_\_\_\_

Visit date: \_\_\_\_\_

BP sitting: \_\_\_\_\_ BP standing: \_\_\_\_\_ BP at home: \_\_\_\_\_ BP target: \_\_\_\_\_

Current weight: \_\_\_\_\_ Weight at previous clinic visit: \_\_\_\_\_

Tolvaptan:  Yes  No

If yes, date started: \_\_\_\_\_ Dose: \_\_\_\_\_

Current Symptoms and Recent Events:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Thirst                 | <input type="checkbox"/> Kidney/flank pain          | <input type="checkbox"/> Headache            |
| <input type="checkbox"/> Nocturia               | <input type="checkbox"/> Hematuria                  | <input type="checkbox"/> Fatigue or weakness |
| <input type="checkbox"/> Decreased appetite     | <input type="checkbox"/> UTI/Other kidney infection | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Fullness/early satiety | <input type="checkbox"/> Kidney stones              | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bloating               | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Sleep disturbance   |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Vomiting                   | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> None                       |  |

Nurse:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dietitian:

Results of most recent 24-hour urine collection: Na: \_\_\_\_\_mmol/day

Calculated Protein Intake: \_\_\_\_\_gm/day

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social Worker:

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Pharmacist:

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Physician:

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Comments/plans:

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