

FIRST VISIT

FIRST VISIT

Name:

date	
height	cm
weight	kg
blood pressure	U-Stix: Proteine _____ Leucocytes _____ Ery _____
laboratory values	
reason for first visit/ medical history / course of disease	
medical treatment/drugs	

daily fluid intake		micturition	/day
edema	<input type="radio"/> No	<input type="radio"/> Yes	
Continance of urine	<input type="radio"/> No	<input type="radio"/> Yes	
recurring urinary tract infections	<input type="radio"/> No	<input type="radio"/> Yes	
gross hematuria	<input type="radio"/> No	<input type="radio"/> Yes	

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Medical history

Perinatal history

gestation week at birth	birth length
birth weight	head circumference at birth
particularities at birth	
peri/postnatal abnormalities	

Prenatal history

oligohydramnios	N	?	Y	first occured in ____ week of gestation; intervention:
gestational diabetes	N	?	Y	first occured in ____ week of gestation; treatment:
drug therapy during pregnancy	N	?	Y	what drugs?
other abnormalities during pregnancy:				
prenatal sonographic abnormalities (please enter weeks of gestation at onset of symptoms)				

Family history

father , year of birth:		disease:			
height		weight		ethnicity	
<i>renal disease</i>	<input type="radio"/> renal cysts	<input type="radio"/> chron. kidney disease	<input type="radio"/> dialysis	<input type="radio"/> ADPKD	
<input type="radio"/> NONE	<input type="radio"/> ARPKD	<input type="radio"/> renal transplantation	<input type="radio"/> Nephronophthisis	<input type="radio"/> HNF1 β	
<i>other renal disease:</i>			participating in any register study?		
mother , geb.:		disease:			
height		weight		ethnicity	
<i>Renale Erkrankung</i>	<input type="radio"/> Nierenzysten	<input type="radio"/> chron. Niereninsuffizienz	<input type="radio"/> Dialyse	<input type="radio"/> ADPKD	
<input type="radio"/> KEINE	<input type="radio"/> ARPKD	<input type="radio"/> Nierentransplantation	<input type="radio"/> Nephronophthise	<input type="radio"/> HNF1 β	
<i>other renal disease:</i>			participating in any register study?		

consanguinity No Unclear Yes degree of relationship?

Siblings

	date of birth	gender	relevant disease
1			
2			
3			
4			

FIRST VISIT

Extended family history

Are other members of the family affected by the patient’s disease or similar symptoms?

Please indicate if the person is participating in a patient register study?

Which family members? (Nr. see below)			
renal cysts	N	?	Y
chronic renal failure	N	?	Y
dialysis	N	?	Y
hepatic cysts	N	?	Y
chronic hepatic failure	N	?	Y
diabetes before the age of 50	N	?	Y
gestational diabetes	N	?	Y
gout's disease	N	?	Y
ARPKD	N	?	Y
ADPKD	N	?	Y
BBS	N	?	Y
nephronophthisis	N	?	Y
HNF1β nephropathy	N	?	Y
any other cystic kidney disease:			
other:			

- | | | |
|-------------------------|-------------------------|------------------|
| 1) maternal grandfather | 6) paternal grandfather | 11) other: _____ |
| 2) maternal grandmother | 7) paternal grandmother | |
| 3) maternal uncle | 8) paternal uncle | |
| 4) maternal aunt | 9) paternal aunt | |
| 5) maternal cousin | 10) paternal cousin | |

Space for family tree (if needed)

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Physical examination

Dermatology, skeleton and left-right axis

postaxial hexadactyly	N	?	Y		brachydaktyly	N	?	Y	
syndactyly	N	?	Y		abnormal nails on fingers or toes	N	?	Y	
thoracic hypoplasia	N	?	Y		short ribs	N	?	Y	
cone shaped epiphyses	N	?	Y		dental abnormalities	N	?	Y	
acanthosis nigricans	N	?	Y		striae	N	?	Y	
exanthema / rash	N	?	Y		situs ambiguus	N	?	Y	
Situs ambiguus	N	?	Y		Situs inversus totalis	N	?	Y	
other:									

Regular orthopedic consultation No Yes (name of specialist):

Gastroenterology

chronic constipation	N	?	Y		Leberzysten	N	?	Y	
chronic diarrhea	N	?	Y		jaundice	N	?	Y	
palpable hepatomegaly	N	?	Y		ascites	N	?	Y	
palpable splenomegaly	N	?	Y		esophageal varices	N	?	Y	
elevated liver enzymes	N	?	Y		hyperphagia	N	?	Y	
cholelithiasis	N	?	Y		Hirschsprung disease	N	?	Y	
gastrointestinal bleeding	N	?	Y	endoscopy (date and result):					
other:									

regular Gastroenterological - consultation No Yes (name of specialist):

Pulmology / ORL

recurring infections of respiratory tract or ORL	N	?	Y		anosmia	N	?	Y	
asthma bronchiale	N	?	Y		paracentesis	N	?	Y	
polyposis nasi	N	?	Y		hearing loss	N	?	Y	
diurnal tiredness	N	?	Y		hearing aid device	N	?	Y	
persistent snoring	N	?	Y			N	?	Y	
other:									

regular pulmonary/ORL consultation No Yes (name of specialist):

FIRST VISIT

Cardiology

cardiac abnormalities	<input type="radio"/> No	<input type="radio"/> Yes:	
dextrocardia	<input type="radio"/> No	<input type="radio"/> Yes:	
24 h RR measurement done?	<input type="radio"/> No	<input type="radio"/> Yes	date performed _____ <input type="radio"/> no hypertension <input type="radio"/> hypertension <input type="radio"/> nocturnal fall of blood pressure normal <input type="radio"/> nocturnal fall of blood pressure not normal <input type="radio"/> other _____ <input type="radio"/> results enclosed
Echocardiography done?	<input type="radio"/> No	<input type="radio"/> Yes	date done _____ <input type="radio"/> normal <input type="radio"/> left ventricular hypertrophy <input type="radio"/> other: _____
ECG done?	<input type="radio"/> No	<input type="radio"/> Yes	date done _____ <input type="radio"/> normal <input type="radio"/> pathologic: _____
other:			

regular cardiologic consultation No Yes (name of specialist):

Central nervous system

ataxia	N	?	Y	
muscular hypotonia	N	?	Y	
microcephalus	N	?	Y	
mental retardation	N	?	Y	
epileptic seizures	N	?	Y	last episode _____ how often? _____
EEG performed	N	?	Y	last EEG _____ <input type="radio"/> normal <input type="radio"/> abnormal:
autoaggression	N	?	Y	
autism spectrum disorder	N	?	Y	
disorder of impulse control	N	?	Y	
learning difficulties	N	?	Y	
Year of schooling and school performance:				
other				

regular neurological consultation No Yes (name of specialist):.

FIRST VISIT

Developmental milestones

free sitting	free walking	continence of urine
free standing	please enter months of life	

Ophthalmology

pupils _____ light reaction _____

loss of vision	N	?	Y		iris coloboma	N	?	Y	
vision aid	N	?	Y		optic nerve atrophy	N	?	Y	
strabism	N	?	Y		achromatopsia	N	?	Y	
astigmatism	N	?	Y		visual field narrowing	N	?	Y	
night blindness	N	?	Y		nystagm	N	?	Y	
oculomotor apraxia	N	?	Y		cataract	N	?	Y	
other:									

regular ophthalmologic consultation No Yes (Name of specialist):.

Sexual development

<input type="radio"/> female	menarche				PH _____ B _____								
<input type="radio"/> male	PH _____ G _____				testicular volume (l/r) _____/_____								
	maldeszensus testis				N	?	Y	hypospadias			N	?	Y
	mikropenis				N	?	Y	scrotum bifidum			N	?	Y
other:													

FIRST VISIT

Renal ultrasound

Name: _____ date _____ examiner _____

renal malformation or dystopy:

renal agenesis	right / left / bilateral	N	?	Y	fused kidney	N	?	Y	
megaureter	right / left / bilateral	N	?	Y	duplex kidneys	right / left / bilateral	N	?	Y
hydronephrosis	right / left / bilateral	N	?	Y	crossed dystopia		N	?	Y
dysplasia	right / left / bilateral	N	?	Y	horseshoe kidney		N	?	Y
other:									

RIGHT KIDNEY

LEFT KIDNEY

localization	<input type="radio"/> orthotopic <input type="radio"/> dystopic: _____	<input type="radio"/> orthotopic <input type="radio"/> dystopic: _____
outer shape	<input type="radio"/> smooth <input type="radio"/> (fetal) lobulation	<input type="radio"/> smooth <input type="radio"/> (fetal) lobulation
renal length	cm	cm
renal width 1	cm	cm
renal width 2	cm	cm
volume	ml	ml
renal pelvis	mm	mm
renal parenchyma	<input type="radio"/> normal <input type="radio"/> high echogenity	<input type="radio"/> normal <input type="radio"/> high echogenity
corticomedullary differentiation	<input type="radio"/> normal <input type="radio"/> reduced <input type="radio"/> abolished	<input type="radio"/> normal <input type="radio"/> reduced <input type="radio"/> abolished
renal cysts	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unclear	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unclear
• localization of cysts	<input type="radio"/> cortical <input type="radio"/> medullar	<input type="radio"/> cortical <input type="radio"/> medullar
• number of cysts	<input type="radio"/> < 5 cysts <input type="radio"/> > 5 cysts	<input type="radio"/> < 5 cysts <input type="radio"/> > 5 cysts
• size of cysts	<input type="radio"/> size < 10 mm (all cysts) <input type="radio"/> size > 10 mm (min 1cyst)	<input type="radio"/> size < 10 mm (all cysts) <input type="radio"/> size > 10 mm (min 1cyst)
lower urinary tract		
urinary tract obstruction	<input type="radio"/> Yes _____ <input type="radio"/> No <input type="radio"/> Unclear	<input type="radio"/> Yes _____ <input type="radio"/> No <input type="radio"/> Unclear
other:		

Abdominal ultrasound

Name: _____ date _____ examiner _____

inhomogeneous hepatic parenchyma	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
hepatic steatosis	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
periportal fibrosis	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
ascites	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
biliary duct dilatation	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	<input type="radio"/> intrahepatic <input type="radio"/> extrahepatic
biliary duct cysts	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
collateral circulation	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	<input type="radio"/> umbilical <input type="radio"/> omentum minus <input type="radio"/> lower liver border <input type="radio"/> spleen
portal flow < 16 cm/sec	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
hepatic cysts	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
liver size in medioclavicular line				cm
pancreatic cysts	<input type="radio"/> No	<input type="radio"/> unclear	<input type="radio"/> Yes	
spleen size				cm
other:				

Any abnormalities of female genitals in abdominal ultrasound: