



Pediatric Kidney Transplant Patient Follow-up Form

Name
MR#
D.O.B.:

Date: _____

Primary Care Doctor / Pediatrician: _____

List any concerns you have about your child's health: _____

List all medications your child is taking.

Drug	Dose	
Neoral (Cyclosporine) _____	mg _____	times / day Bactrim _____ tsp. / tabs per day
Prograf _____	mg _____	times / day Multivitamin <input type="checkbox"/> Yes <input type="checkbox"/> No
Prednisone _____	mg _____	times / day List all medication allergies
Cell Cept _____	mg _____	times / day _____
Valcyte _____	mg _____	times / day _____
Zantac _____	mg _____	times / day _____
Mycelex _____	mg _____	times / day
_____	mg _____	times / day
_____	mg _____	times / day
_____	mg _____	times / day
_____	mg _____	times / day
_____	mg _____	times / day

Does your child have any of the following problems? Explain in the space to the right.

Constitutional Symptoms

Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weight changes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Feeding/eating problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other: _____		

Eyes

Blurred / Double Vision	<input type="checkbox"/> Y	<input type="checkbox"/> N
Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other: _____		

Allergic/Immunologic

Hay Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other: _____		

Neurological

Seizures	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weakness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Numbness/tingling	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other: _____		

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Endocrine

Excessive thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other: _____

Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Constipation Y N
Other: _____

Cardiovascular

Chest Pain Y N
Heart Murmur Y N
High Blood Pressure Y N
Other: _____

Integumentary

Skin Rash / Boils Y N
Lasting Itch Y N
Other: _____

Musculoskeletal

Joint Pain Y N
Neck Pain / Back Pain Y N
Other: _____

Ear/Nose/Throat/Mouth

Ear infection Y N
Sore Throat Y N
Sinus Problems Y N
Other: _____

Genitourinary

Urine Infection Y N
Wetting Accidents Y N
Urinary Frequency Y N
Other: _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Pneumonia Y N
Other: _____

Hematologic/Lymphatic

Swollen Glands Y N
Blood Clotting Problem Y N
Other: _____

Psychologic

Personality changes Y N
Hyperactivity Y N
Difficulty concentrating Y N
Memory trouble Y N
Other: _____

M.D. / D.O.