

# The Childrens' Clinic

## Constipation History

Name of child \_\_\_\_\_

Name(s) of person(s) who filled out this form

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Date form filled out \_\_\_\_\_

## Bowel Function

How long was your child breast fed? \_\_\_\_\_ months

Describe any problems you had with breast feeding.

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At what age did you introduce formula? \_\_\_\_\_ months

At what age did you introduce solids? \_\_\_\_\_ months

After your child started walking, describe how you knew your child had pooped.

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Describe your experiences with toilet training for poop.

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Does (did) your child hold in the poop? Describe what you see (saw).

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Describe the child care arrangements for your child during the first 4 years of life (Parents only, relatives, dayhome or daycare, pre-school)

Birth to age 1 year \_\_\_\_\_

1 to 2 years \_\_\_\_\_

2 to 3 years \_\_\_\_\_

3 to 4 years \_\_\_\_\_

Has your child ever had constipation? Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes;** describe

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**If Yes;** was your child treated with:

Diet changes? Yes \_\_\_\_\_ No \_\_\_\_\_

Stool softener? Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes;** which stool softener? \_\_\_\_\_

Glycerine suppositories? Yes \_\_\_\_\_ No \_\_\_\_\_

Enemas? Yes \_\_\_\_\_ No \_\_\_\_\_

How many days a week does your child have a bowel movement? \_\_\_\_\_ days

When does your child have a bowel movement?

after breakfast \_\_\_\_\_ at school \_\_\_\_\_ after school \_\_\_\_\_ after supper \_\_\_\_\_ before bed \_\_\_\_\_ at random times \_\_\_\_\_

Is the stool wider than you would expect? Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes;** how wide? \_\_\_\_\_ inches

Has the poop ever plugged the toilet?

Yes\_\_\_\_No\_\_\_\_

Is the stool hard and difficult to pass?

Yes\_\_\_\_No\_\_\_\_

Does your child push to poop?

Yes\_\_\_\_No\_\_\_\_

Does your child soil their underwear?

Yes\_\_\_\_No\_\_\_\_

**If Yes;**

at least once a day\_\_\_\_\_

several times a week\_\_\_\_\_

once a week\_\_\_\_\_

less than once a week\_\_\_\_\_

once a month\_\_\_\_\_