

Voiding History

Name of child _____

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

Date form filled out _____

Toilet Training

What age did your child pee on their own? _____ Years

When was your child out of diapers by day? _____ Years

When was your child consistently dry at night? _____ Years

Were there problems with Toilet Training? **If Yes;** describe

Voiding Pattern

How many times a day does your child void?

less than 5 _____

about 5 _____

5 to 10 _____

over 10 _____

Estimate how long between voiding? _____ minutes

Has a school teacher ever mentioned that your child peed frequently? **If Yes;** describe

Does your child void frequently in any of these situations:

after drinking a lot? Yes____No____

on car trips? Yes____No____

in movie theatres? Yes____No____

Does your child have to run to the bathroom? Yes____No____

If Yes;

with most voids_____

at least once per day_____

most days_____

at least once a week_____

When do you most often see your child running to pee?

Does your child hold the pee until the last minute? Yes____No____

If Yes; describe the typical holding postures

What are the common situations when your child holds the pee?

(Girls) Does your child squat to prevent wetting? Yes____No____

If Yes;

Is the squat painful? _____

Does your child look flushed? _____

How long does the squat last? _____minutes

Does your child get up from the supper table to pee? Yes____No____
If Yes; how many days a week? _____

Does your child have the sensation of wetness, or of urine coming out,
or of having to pee immediately (within a few minutes) after voiding?
Yes____No____
If Yes; describe

Does your child have the sensation of having to go again within a few
minutes of peeing? Yes____No____
If Yes; is this sensation more common at bedtime? Yes____No____

How often does your child **wet by day** sufficient to change their
clothes?
more than once a day_____
once a day_____
most days_____
at least once a week_____

How often is your child's underwear just **damp** (small stains)?
most voids_____
at least once per day_____
most days_____
at least once a week_____

Does your child wet:
with sports? _____; **If Yes;** which sports? _____
with sneezing or coughing? _____
with laughing or tickling? _____
If your child wets with laughing is the amount a little ____
or a lot ____ (bladder empties completely).

Other Problems

Has your child ever been assessed or diagnosed with any of these problems:

ADHD	Yes_____No_____
Learning Disorder	Yes_____No_____
Delayed Development?	Yes_____No_____
Behavioral Problem?	Yes_____No_____
Neurological problem?	Yes_____No_____

Are you concerned your child might have any of these problems?

If Yes; please describe your concerns

Personality

Please describe your child's personality in single words.

Please rate your child's reaction to having a full bladder while on a car trip. Would your child:

Just hold it and wait till the next bathroom _____

Wet the underwear _____

Calmly request that you stop or find a bathroom _____

Panic _____

On a scale of 1 to 10, please rate the following personality features in your child; 10 implies most perfectionist, etc

Perfectionist _____

Meticulous _____

Organized _____

Urine Infection

Has your child ever had a urine infection? Yes____No____

If Yes;

"all the time" _____

once a month_____

more than four times a year _____

less than four times a year_____

Has your child ever had a kidney infection? Yes____No____

Has your child ever had:

kidney ultrasound? Yes____No____

bladder X-ray with catheter (VCUG) Yes____No____

kidney scan (IV injection and X-ray) Yes____No____

If Yes; please provide dates and location where the test was done

Has anyone every told you that your child has high blood pressure or protein in the urine? _____

Does your child complain of pain with voiding? Yes____No____

Does the urine have a bad odor? Yes____No____

Have you ever seen fresh blood in the urine? Yes____No____

Girls:

Does your daughter get red in the genital area? Yes____No____

If Yes;

every day_____

at least once a week_____

at least once a month_____

Does your child have a yellow or green discharge? Yes____No____

Has your child ever had labial adhesions? Yes____No____

Boys:

Is your son circumcised?

Yes____No____

If Yes; was the circumcision at birth?

Yes____No____

What was the reason for the circumcision?

religious_____

parental preference _____

medical problem _____; **If Yes;** please describe

Does the foreskin retract behind the penis?

Yes____No____

Has your son ever had a foreskin infection?

Yes____No____

Does the foreskin balloon out with voiding?

Yes____No____

Describe any foreskin concerns.

Stream Abnormalities

Does your child need to wait to initiate voiding? Yes____No____

If Yes; for how long? _____ seconds

Does your child need to push to initiate voiding? Yes____No____

If Yes; Is there an audible grunt? Yes____No____

Is the stream strong or weak? Strong____Weak____

Does your child rush voiding? Yes____No____

Is the stream continuous?____or does it start and stop?____

If the stream stops, is this just towards the end?

Yes____No____

(Boys) Is the stream straight? Yes____No____

Has your child had a catheter in the bladder? Yes____No____

Has your child had an injury to the genital area? Yes____No____

Bowel Function

How long was your child breast fed? _____ months

Did you supplement with formula while breast feeding? Yes ___ No ___

Describe any problems you had with breast feeding.

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.

Describe your experiences with toilet training for poop.

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

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

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 in a typical week does your child have a bowel movement? Circle one number. 1 2 3 4 5 6 7

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 every 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 (poop) 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____

at night while asleep____

Bedwetting

Does your child wet at night?

Yes____No____

If Yes;

How many times each night? _____

What times? _____

Describe how you know that your child wets more than once.

What is the longest number of consecutive nights that your child has gone dry? _____ nights

Describe the circumstances of this dry spell.

Does your child wake up when they wet?

Yes____No____

Does your child wake cold and wet after wetting?

Yes____No____

If Yes; What time? _____

Does your child get up to void?

Yes____No____

If Yes; What time? _____

Does (did) your child wet:

during naps?

Yes____No____

if they fell asleep during daytime car trips?

Yes____No____

Describe how the wetting embarrasses your child.

Does your child wear a pull-up? Yes____No____

If Yes; what brand? _____

If Yes; is the pull up:

Damp? _____

Average wet? _____

Soaked? _____

Soaked through into the sheets?_____ **If Yes;** how many days a week does your child soak through into the sheets? _____

Does your child every wear the pull-up to watch TV on weekend mornings? Yes____No____

Is your child a deep sleeper? Yes____No____

Does your child snore? Yes____No____

If Yes;

Does your child ever stop breathing? Yes____No____

Is your child hard to wake in the morning? Yes____No____

Does your child wake up refreshed? Yes____No____

Is your child tired at school in the morning? Yes____No____

Is your child a mouth breather during the day? Yes____No____

Has your child had a tonsillectomy & adenoidectomy?

Yes____No____

If Yes; at what age and for what reason?

Is there a family history of bedwetting? Yes____No____

If Yes;

Mother _____ Father_____ Brother_____ Sister_____

Aunt_____ Uncle_____ Grandparent_____ Other _____

When your child voids first thing in the morning,

after wetting the bed,

is the volume of urine a little or a lot? Little____Lot____

Does your child have night terrors? Yes____No____
Does your child sleep walk? Yes____No____
Does your child talk in their sleep? Yes____No____
Does your child grind their teeth during sleep? Yes____No____
Does your child sleep restlessly? Yes____No____
Does your child have nightmares? Yes____No____

Do you restrict fluids in the evening? Yes____No____
Does your child always void before bed? Yes____No____
Do you take your child to void before you go to sleep? Yes____No____

What treatments have you tried?

Alarm? _____

DDAVP? _____

Tofranil (imipramine)? _____

Ditropan (oxybutynin)? _____

Detrol (tolterodine)? _____

Other? _____
