

VOIDING HISTORY

PATIENT NAME: _____

Please complete this questionnaire as accurately as possible. The information you provide is vital to us in selecting the best treatment plan.

Instructions: If you answer "Yes" to the following questions, list the date this occurred to the closest month and year. If your child is still experiencing the problem, check the box under "Ongoing."

1. Has your child experienced any of the following:	Yes	Month/Year	Ongoing	No
Pain in urinating (passing water)	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Need to void urgently (in a hurry)	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Voiding frequently (voiding often)	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Squatting to void	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Frequent nighttime voiding	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Before falling asleep	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
After falling asleep	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Frequent daytime voiding	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Excessive thirst	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Dribbling stream when voiding	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Visible blood in urine	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Blood in urine on urine test	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Infection in urine (UTI)	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Both day and night wetting	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Daytime wetting only during naps	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Daytime wetting before going to toilet	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Daytime wetting after going to toilet	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Wetting without trying to get to toilet	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Lack of awareness that he/she is urinating	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Dribbling after urinating	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Avoidance of toilets away from home or at school	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
No need to urinate upon awakening in morning	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Abdominal (stomach) pain	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Holding bowel movements	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>

2. Has anyone in the family had bed-wetting problems? If so, who?

3. Tell us about your child's medical history:

a. Which other doctors has your child seen? List name of doctor and approximate date and reason seen.

Name of Doctor	Month/Year	Reason
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

b. List past hospitalizations and dates.

c. List surgical operations and dates.

d. List medications your child takes now.

e. Was your child born "on time," early, late? List problems during pregnancy, delivery or at time of birth.

f. Tell us about early wetting. Describe diaper wetness and number of times a day you changed your child.

g. At what age did toilet training start? _____
At what age did your child control bowel movements? _____
At what age was daytime urinary control obtained? _____
At what age was nighttime urinary control obtained? _____

h. Describe any problems with physical, brain or reflex development.

i. Describe any behavioral or emotional problems.

j. Tell us about any problems at school.

k. What treatment, if any, has been used to help with urine control?

