PEDIATRIC UROLOGY PATIENT QUESTIONNAIRE

Please complete this questionnaire and bring it to your next appointment.

Your name: ___________________________ Relationship to patient ___________________________

DAY-TIME HABITS

1. How often does your child urinate (pee) during the day?
   - [ ] every 1-2 hours
   - [ ] every 3-4 hours
   - [ ] every 5-6 hours
   - [ ] other, please explain

2. Does your child have wetting (peeing) accidents during the day? [ ] No  [ ] Yes
   If no, go to question #8

3. At what age did these accidents start?

4. Does your child have wetting accidents everyday? [ ] No  [ ] Yes
   If yes, how many accidents does your child have each day?
   ___________________________
   If no, how many days each week do the accidents occur?
   ___________________________

5. Do you ever see your child "squat" or "dance" when needing to pee? [ ] No  [ ] Yes

6. Does your child seem to know when they are going to have an accident? [ ] No  [ ] Yes

7. Have you ever tried any treatments for these accidents? [ ] No  [ ] Yes
   If yes, what have you tried?

NIGHT-TIME HABITS

8. Does your child have wetting accidents at night? [ ] No  [ ] Yes
   If no, go to question #12 on back of form

9. Has your child ever been dry every night for six months or longer? [ ] No  [ ] Yes

10. How often are these night-time accidents?

   ______ every night ______ times per week
   (please fill in the number) ______ times per month
   (please fill in the number)

11. What have you tried to manage the night-time wetting?
    (mark all that apply)

    ______ limiting fluids after dinner
    ______ diapers, Pull-ups™
    ______ waking child and taking to the bathroom
    ______ setting alarm clock
    ______ using moisture sensing alarm system
    ______ medication:
       ______ DDAVP™, either spray or tablet
       ______ Imipramine

→PLEASE TURN OVER→
BOWEL HABITS

12. Does your child have a bowel movement (poop) every day?  No □   Yes □
13. Does your child ever complain that it hurts to poop?  No □   Yes □
14. Does your child ever have poop accidents in the underpants?  No □   Yes □
15. Has your child ever been treated for constipation (hard poops)?
   If yes, what has been tried? (mark all that apply)
   □ sitting program          □ stool softener
   □ suppositories            □ mineral oil
   □ enemas                    □ Senokot®

   Other medications (please list) ____________________________________________

FAMILY HISTORY (child’s parents, brothers and sisters, aunts and uncles, grandparents)

16. Are there any family members whom have had surgery on their urinary tract system?  No □   Yes □
   If Yes, whom? ____________________________________________________________

17. Are there any family members who had night time wetting?  No □   Yes □
   If Yes, whom? ____________________________________________________________
   How old were they when they stopped? ________________________________________

18. Is there a history of diabetes in your family?  □ No □   Yes □ If yes, who? ____________________________

19. Is there a history of kidney or bladder disease in your family?  □ No □   Yes □ If yes, who? ____________________

URINARY TRACT INFECTION (UTI)

20. Has your child ever had a urinary tract infection?  No □   Yes □
   If No, stop here.

21. Did child have a fever of 101° or higher with the infection?  No □   Yes □

22. After the infection, did your child have any x-rays of the urinary system?  No □   Yes □

23. How old was your child when he/she had the infection? _______________________

24. Has your child had more than one infection?  No □   Yes □
   If No, go to question #27.

25. How many urinary tract infections has your child had? _______________________

26. How many urinary tract infections in the past year? _______________________

27. Did your child require hospitalization for a urinary tract infection?  No □   Yes □

OTHER

28. Are you concerned that your child may have suffered abuse of any kind?  No □   Yes □

29. List any other concerns or comments you feel are important _______________________________________

_________________________________________  ______________  ____________
Provider (Print Name)                         Provider Signature        Date                Time