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PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages prior to your child's appointment.

Name of parent or guardian completing this form _____

Child's name: _____

Describe the reason for your child's appointment _____

When did this problem begin? _____ Is it getting better_worse_____ staying the same __

Name and date of child's last doctor visit _____ Date of last urinalysis _____

Previous tests for the condition for which your child is coming to therapy. Please list tests and results _____

<u>Medications</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates. _____

Does your child now have or had a history of the following? Explain all "yes" responses below.

- | | |
|-------------------------------|--|
| Y/N Pelvic pain | Y/N Blood in urine |
| Y/N Low back pain | Y/N Kidney infections |
| Y/N Diabetes | Y/N Bladder infections |
| Y/N Latex sensitivity/allergy | Y/N Vesicoureteral reflux Grade _____ |
| Y/N Allergies | Y/N Neurologic (brain, nerve) problems |
| Y/N Asthma | Y/N Physical or sexual abuse |
| Y/N Surgeries | Y/N Other (please list) _____ |

Explain yes responses and include dates _____

Does your child need to be catheterized? Y/N If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day? _____ times per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____ times
3. Does your child awaken wet in the morning? Y/N If yes, _____ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)

- | | | |
|-----------------|-------------------|--|
| ___ Not at all | ___ 3-10 minutes | |
| ___ 1-2 minutes | ___ 11-30 minutes | |

___ 31-60 minutes

___ Hours

6. Does your child take time to go to the toilet and empty their bladder? Y/N
7. Does your child have difficulty initiating the urine stream? Y/N
8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N
13. Fluid intake (one glass is 8 oz or one cup)
___ of glasses per day (all types of fluid)
___ of caffeinated glasses per day
Typical types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list _____

Bowel Habits

15. Frequency of movements: ___ per day ___ per week. Consistency: loose___ normal___ hard___
16. Does your child currently strain to go? Y/N_____ Ignore the urge to defecate? Y/N_____
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N_____ How long has it been a problem?___

SYMPTOM QUESTIONNAIRE

- | | |
|--|---|
| <ol style="list-style-type: none">1. Bladder leakage (check all that apply)
___ Never
___ When playing
___ While watching TV or video games
___ With strong cough/sneeze/physical exercise
___ With a strong urge to go
___ Nighttime sleep wetting2. Frequency of urinary leakage-number (#) of episodes
___ # per month
___ # per week
___ # per day
___ Constant leakage3. Severity of leakage (circle one)
___ No leakage
___ Few drops
___ Wets underwear
___ Wets outer clothing7. Protection worn (circle all that apply)
___ None
___ Tissue paper / paper towel
___ Diaper
___ Pull-ups8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10
0 _____ 10 | <ol style="list-style-type: none">4. Bowel leakage (check all that apply)
___ Never
___ When playing
___ While watching TV or video games
___ With strong cough/sneeze/physical exercise
___ With a strong urge to go5. Frequency of bowel leakage-number (#) of episodes
___ # per month
___ # per week
___ # per day6. Severity of leakage (circle one)
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying |
|--|---|

