

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 | ___ 11-30 minutes |
| ___ 1-2 minutes | ___ 31-60 minutes |
| ___ 3-10 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

- | | |
|---|--|
| <p>1. Bladder leakage (check all that apply)</p> <p>___ Never
 ___ When playing
 ___ While watching TV or video games
 ___ With strong cough/sneeze/physical exercise
 ___ With a strong urge to go
 ___ Nighttime sleep wetting</p> <p>2. Frequency of urinary leakage-number (#) of episodes</p> <p>___ # per month
 ___ # per week
 ___ # per day
 ___ Constant leakage</p> <p>3. Severity of leakage (circle one)</p> <p>___ No leakage
 ___ Few drops
 ___ Wets underwear
 ___ Wets outer clothing</p> <p>7. Protection worn (circle all that apply)</p> <p>___ None
 ___ Tissue paper / paper towel
 ___ Diaper
 ___ Pull-ups</p> <p>8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10</p> <p>0 _____ 10
 Not a problem Major problem</p> <p>9. Rate the following statement as it applies to your child's life today</p> <p style="text-align: center;">My child's bladder is controlling his/her life.</p> <p>0 _____ 10
 Not true at all Completely true</p> | <p>4. Bowel leakage (check all that apply)</p> <p>___ Never
 ___ When playing
 ___ While watching TV or video games
 ___ With strong cough/sneeze/physical exercise
 ___ With a strong urge to go</p> <p>5. Frequency of bowel leakage-number (#) of episodes</p> <p>___ # per month
 ___ # per week
 ___ # per day</p> <p>6. Severity of leakage (circle one)</p> <p>___ No leakage
 ___ Stool staining
 ___ Small amount in underwear
 ___ Complete emptying</p> |
|---|--|