Patient Label

Voiding History – Pediatric Urology

To be completed on children with UTI's and wetting problems.

Instructions: If you answer "Yes" indicate date that this occurred, check "Ongoing" if your child is still experiencing the problem.

Has your child experienced any of the following:	**Yes**	**Month/Yr**	**Ongoing**	**No**
Pain when urinating	___	_____	___	___
Blood in urine	___	_____	___	___
Infection in urine (cloudy, smelly, urine)	___	_____	___	___
Need to urinate urgently	___	_____	___	___
Frequent daytime urinating	___	_____	___	___

Estimate how many times your child urinates during the day (circle)

1-3 **4-6** **7-9** **10-12** **More Than 12**

Can your child sit through 2 hours of TV or ride in the car without urinating? (circle)

Almost always **Half of the time** **Less than half of the time** **Almost never**

	Yes	**Month/Yr**	**Ongoing**	**No**
Both day and night wetting	___	_____	___	___
Bedwetting	___	_____	___	___
Daytime wetting only during naps	___	_____	___	___
Daytime wetting <u>before</u> going to toilet	___	_____	___	___
Wetting without trying to get to toilet	___	_____	___	___
Lack of awareness that he/she is urinating	___	_____	___	___
Dribbling <u>after</u> urinating	___	_____	___	___
Dribbling stream <u>when</u> urinating	___	_____	___	___
A "start and stop" stream	___	_____	___	___
An explosive stream with an abrupt stop	___	_____	___	___
"Straining" with voiding	___	_____	___	___
Squatting posture associated with need to urinate/ push heel into bottom	___	_____	___	___
No need to urinate upon awakening in morning	___	_____	___	___
Avoidance of toilets away from home or at school	___	_____	___	___

Constipation

How often does your child have BM's? (circle)

1-2 times/day **every other day** **every 3-4 days** **more than 4 days**

Describe consistency: (circle)

Hard, dry lumps or marbles soft, formed loose, unformed watery

	Yes	**Month/Yr**	**Ongoing**	**No**
Large stools that clog plumbing	___	_____	___	___
Holding Bowel movements	___	_____	___	___
Stool soiling	___	_____	___	___
Passage of blood in stool	___	_____	___	___
Abdominal (stomach) pain	___	_____	___	___
Snoring	___	_____	___	___
Excessive thirst	___	_____	___	___

What does he/she drink the most? _____

If your child is having urinary accidents;

Is their clothing or pull-ups damp ____ wet ____ or soaking wet ____?

How often is a change of clothing required? _____

Do they lose urine by continuous dribbling? (circle) Yes/No or in small spurts? Yes/No

Is the urine accident related to any type of activity? _____

_____

Has your child ever been dry for more that 6 months? Yes/No

Were there any stressful or emotional events that coincided when symptoms began?
Yes/No

If Yes, Please Explain: _____

_____

What treatment, if any has been used to help with urine control or infections? _____

_____

_____

Name of person completing form: _____

Reviewed by: _____ Date _____