Pediatric Urology Associates, P.C.

Michael H. Fleisher, M.D., FAAP, FACS
Thomas S. Vates III, M.D., FAAP, FACS
Dawn Gerdes, MS, RN, APN-C

Main Office
557 Cranbury Road
East Brunswick, N.J. 08816
(732)613-9144

Monmouth Office
422 Morris Avenue
Long Branch, N.J. 07740

Dear Parent,

Attached is a voiding questionnaire for you and your child to complete together prior to your first appointment with us. It is the philosophy of Pediatric Urology Associates to approach wetting issues as a "team". This questionnaire is the beginning of the team approach that will assist us in achieving the best possible outcome for your child. We pledge to work with you and your child to achieve the best possible outcome.

Although this questionnaire is lengthy, the more detail we have about what your child is experiencing the better we can prepare a plan of care to address your child's symptoms. If there is any additional information that would be important for us to know about your child, please feel free to share it with us under the "comments" section on page 4.

I look forward to meeting with you and your child and thank you for allowing us to participate in your child's care.

Dawn Gerdes, MS, RN, APN-C
Pediatric Urology Associates, P.C.

Pediatric Urology Associates
Voiding Questionnaire

Name:_____**Nickname:**_____

DOB:_____**Age:**_____**Sex:**_____

Height:_____**Weight:**_____**Allergies**_____

Pediatrician:_____

Family Members:

Name	Relationship	Sex	Age	Voiding Problems

Past Medical History:

Circle appropriate response.

Diabetes Y or N	Urologic Y or N	Asthma/Bronchitis Y or N	Cardiac anomalies Y or N	Bleeding Disorder Y or N
Trauma (spine or pelvis) Y or N	ADD/ADHD Y or N	Anxiety Disorder Y or N	Cerebral Palsy Y or N	Spina Bifida Y or N

Past Surgical History:

Circle appropriate response, if Yes to any please describe.

Urologic Y or N	Pelvic Y or N	Spinal Y or N
List any other surgery:		

Current Medications:

Name	Dose	Route	Frequency	Reason for Medication

Has your child been treated in the past for voiding dysfunction, for example, bedwetting, or day wetting, and or constipation? If yes, please describe treatment.

_____

_____

_____

Dysfunctional Voiding Scoring System

Please assist your child in answering these questions and circle appropriate response.

Over the last Month	Almost Never	Less than half the time	About half the time	Almost every time	Not available
1. I have had wet clothes wet underwear during the day.	**0**	**1**	**2**	**3**	**NA**
2. When I wet myself, my underwear is soaked.	**0**	**1**	**2**	**3**	**NA**
3. I miss having a bowel movement everyday.	**0**	**1**	**2**	**3**	**NA**
4. I have to push for my bowel movements to come out.	**0**	**1**	**2**	**3**	**NA**
5. I only go to the bathroom on e or two times each day.	**0**	**1**	**2**	**3**	**NA**
6.I can hold onto my pee by crossing my legs, squatting or sing the “pee dance”	**0**	**1**	**2**	**3**	**NA**
7. When I have to pee, I cannot wait.	**0**	**1**	**2**	**3**	**NA**
8. I have to push to pee.	**0**	**1**	**2**	**3**	**NA**
9. When I pee it hurts.	**0**	**1**	**2**	**3**	**NA**
10. Parents to answer. Has your child experienced something stressful like the example below?	**No (0)**	**No (0)**	**No (0)**	**YES (3)**	**Yes (3)**
TOTAL					

Question 10: A new baby, a new home, a new school, school problems,

abuse (sexual /physical), home problems (divorce/death).

Please check appropriate box.

How often is your child wet at night?

Never	1-2 times per month	2-3 times per week	Daily	Unsure

How often does your child wake at night to urinate?

Never	1-2 times per month	2-3 times per week	Daily	Unsure

How many urinary tract infections (UTI's) has your child had during the past year?

None	1-3	4-6	Greater than 6

When your child's urine was collected to be tested, how was it obtained?

Bag	Voided	Clean catch mid stream	Catheterization

What symptoms were associated with UTI, mark all that apply?

Fever	Flank Pain	Vomiting	Pain & Urinating	Foul odor

Is your child incontinent of stool?

Never	Occasionally	Frequently

What is your child's stool consistency?

Hard small "rock-like"	Soft and formed	Liquid		

Does your child routinely drink or eat any of the following items?

Soft drinks	Chocolate	Lemonade	Coffee/Teas/Colas	Orange juice

Comments: