Boston Children's Hospital

Use Plate, Label, or Print:

Name:

BCH MRN#:

DOB: Gender: M F

VOIDING IMPROVEMENT PROGRAM (VIP) QUESTIONNAIRE

Please fill out this questionnaire prior to your visit with us at
The Voiding Improvement Program "VIP"
Please ask your child to assist you in answering these questions. All Information is Confidential

Date: **Name (Printed) of Person Completing This Form:** **Specify Relationship to Patient or Specify Patient**

BIRTH HISTORY:

1. Were there any respiratory or other complications at birth? Yes ___ No___
   If yes, describe: _____
2. Did your child spend any time in the neonatal ICU? Yes___ No___
   If yes, how long was he/she in the neonatal ICU and for what reason?
   _____
3. Did he/she receive oxygen at birth? Yes___ No___
4. Did your child get placed under special lights for having jaundice? Yes___ No___
5. Number of pregnancies *before* your child was born? _____
6. Were there any difficulties during the pregnancy? Yes___ No___
   If Yes, please explain_____
7. Was your child delivered: Vaginally ____ C-Section ____
   If yes to C-Section, for what reason: _____

DEVELOPMENT:

1. How old was your child when he/she began to sit up? _____
2. How old was your child when he/she began to crawl? _____
3. How old was your child when he/she began to walk? _____
4. How old was your child when he/she said the first words? _____
5. What hand does your child use for writing or what is their prominent hand?
   Right _____ Left _____ Unsure _____
6. If your child is left-handed, are there any other family members that are left handed?
   Yes___ No___
7. How old was your child when he/she was toilet trained?
   Day (list age or never) _____ Night (list age or never) _____
8. Has your child ever been diagnosed with toe-walking? Yes___ No___

GENERAL HEALTH:

1. Does your child do any of the following in their sleep? Check all that apply:
   Talk____ Snore ____ Walk ____ Grind their teeth ____
2. Does your child have any learning disabilities/Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD)/Autism/Asperger's? Yes___ No___
   If yes, please explain: _____
3. Has your son/daughter ever been treated by a psychologist, counselor or psychiatrist?
   Yes___ No___
   If yes, please explain:_____
4. Is your child performing at grade level? Yes___ No___
5. Does your child receive special services at school (e.g. IEP, 504 plan, speech, reading?)
   Yes___ No___
   If yes, please explain:_____
6. Is your child able to focus well on tasks? Yes___ No___

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FAMILY HISTORY:

1. Do any relatives have a history of: (Note: relatives include mother, father, sister, brother, grandparents, aunts, uncles, and first cousins)

Wetting: Day ___ Night ___	Relative: _____ age resolved _____
Wetting: Day ___ Night ___	Relative: _____ age resolved _____
Wetting: Day ___ Night ___	Relative: _____ age resolved _____
Urinary tract infection	Relative(s) _____
Kidney infections	Relative(s) _____
Surgery on kidney/bladder	Relative(s) _____
Neurological Problems	Relative(s)_____Diagnosis_____
	Relative(s)_____Diagnosis_____

SOCIAL HISTORY:

Just like adults, children can feel the stress of everyday life. Stress may or may not contribute to a child's wetting problem. Were there any changes that occurred *on or around the time* your child's wetting problem began or worsened?

1. Has your family moved to a new home? Yes___ No___
2. Has there been a change in parent's marital status? (marriage, divorce, separation) Yes___ No___
3. Has there been the death of a parent, sibling, close relative, friend? Yes___ No___
4. Has there been serious illness of a parent, sibling, close relative, or friend? Yes___ No___
5. Has there been a birth or adoption of a new child? Yes___ No___
6. Has your child changed bedrooms? Yes___ No___
7. Has there been a change in the family financial situation? Yes___ No___
8. Has there been a change in a daytime caretaker/day care or school? Yes___ No___
9. Has a family member been a victim of violence? Yes___ No___
10. Has there been an increased absence of a parent from home due to job demands? Yes___ No___
11. Has a parent started to work outside the home or changed jobs? Yes___ No___
12. Has there been a significant change in school performance? Yes___ No___

UROLOGIC HISTORY:

1. Are there large gaps of time between your child's urinating (e.g. not using the bathroom at school)? Yes___ No___
   If yes, please explain: _____
2. Approximately how many times in a 24 hr period does your child urinate?
   2 - 3 _____ 4 - 6 _____ 7 - 12 _____ 13 – 20_____ More than 20 _____
3. Does your child wake to urinate at night? Yes___ No___
   If yes how often? # of days per week_____ and # of times per night_____
4. How would you describe your child's flow of urine?
   Continuous _____ Start and stop _____ Forceful _____ Weak _____
5. Does your child have any difficulty starting urination? Yes___ No___
6. When is the first time he/she urinates in the morning? _____
7. Does he/she have loss of urine with laughing or coughing? Yes___ No___
8. Is your child ever unable to urinate when he/she feels the urge to go? Yes___ No___
   If yes, how often does this occur? _____
9. Has your child ever had blood in his/her urine? Yes___ No___
   If yes, please explain: _____
10. Have you ever noticed anything in your child's urine (e.g. stones/gravel)? Yes___ No___

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URINARY POSTPONEMENT:

1. Does he/she delay/avoid using the bathroom while involved in activities, such as playing, watching TV, etc.? Yes___ No___
2. Does he/she need to run the bathroom urgently after holding urine for a long time? Yes___ No___
3. Does he/she claim that they "didn't know they had to go"? Yes___ No___
4. Does your child twist his/her body, "dance", cross his/her legs, or squat down in order to prevent an accident or to stop the urge to urinate? Yes___ No___

WETTING: (PLEASE SKIP THIS SECTION IF YOUR CHILD HAS NOT EXPERIENCED THIS)

1. Is your son's/daughter's wetting occurring (choose only one):
   Daytime ***Only*** ____
   Night time ***Only*** ____
   Both daytime and night time ____
2. When did these symptoms begin? _____
3. Has there ever been at least a 3 month period of dryness during the **daytime**? Yes___ No___
4. How many ***days per week*** does your child have an accident during daytime?
   7 _____ 4 - 6 _____ 1 - 3 _____ <1 _____ None _____
5. Has there ever been at least a 3 month period of dryness during **nighttime**? Yes___ No___
6. How many ***nights per week*** is your child wet?
   7 _____ 4 - 6 _____ 1 - 3 _____ <1 _____ None _____
7. How would you describe the volume or amount of these accidents?

	Day:	**Night:**
Very large, clothes completely soaked	_____	_____
Underwear wet but clothing mostly dry	_____	_____
Underwear is damp	_____	_____
Very small (size of a quarter)	_____	_____
Combination of above	_____	_____

8. Where does wetting occur (check all that apply):
   Home ____ School ____ After school _____ Camp ____ Day care ____
   On trips ____ In the car ____ Friend's house ____ Relative's house ____

URINARY FREQUENCY: (PLEASE SKIP THIS SECTION IF YOUR CHILD HAS NOT EXPERIENCED THIS)

1. Does your child feel the need to urinate again, shortly after having just urinated in the bathroom? Yes___ No___
2. Did your child have any viral illnesses or "cold" symptoms within one month prior to the onset of his/her symptoms? Yes___ No___

   If yes, please explain: _____

PAINFUL URINATION AND/OR INFECTION: (PLEASE SKIP THIS SECTION IF YOUR CHILD HAS NOT EXPERIENCED THIS)

1. Does he/she complain of pain or burning when he/she urinates? Yes___ No___
2. If yes, how often _____
3. Has your child ever had a urinary tract infection? Yes___ No___
   If yes, how many infections and at what ages(s)? _____
4. Was there a fever with any of these infections? Yes___ No___
5. Were these infections treated with antibiotics? Yes___ No___

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DIET:

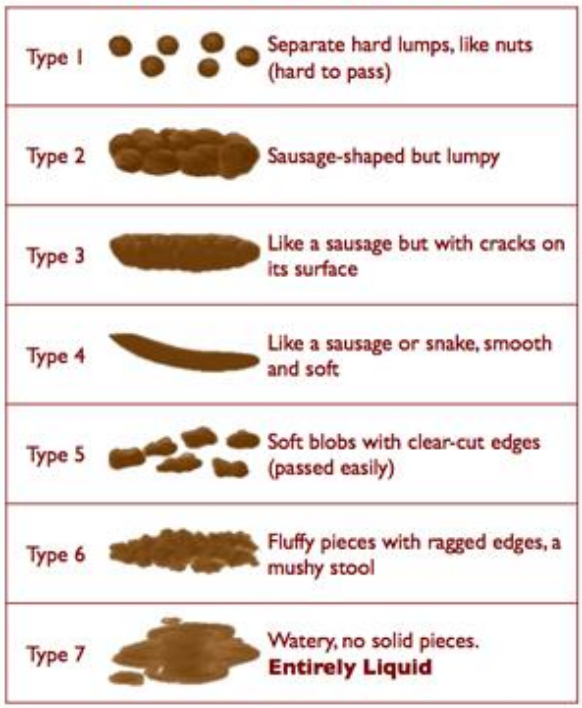
1. What does your child drink during the day? Check all that apply.
   Soda ___ Milk ___ OJ ___ Iced Tea ___ Kool Aid/Hi C ___ Gatorade ___
   tap water ___ bottled water ___ Other _____
2. Is there any caffeine in your child's diet? (i.e. chocolate, energy drinks, tea, coffee)
   Yes___ No___
3. Approximately how many glasses of liquid does your child drink per day?
   (include the total number of glasses or ounces)_____
4. What time do you normally eat dinner?_____
5. Does your child drink after dinner? Yes___ No___
   If yes, what does he/she drink and how much? _____
6. What time does he/she normally go to bed?_____

BOWEL HABITS: (PLEASE ANSWER THESE QUESTIONS WITH YOUR CHILD, YOU MIGHT BE SURPRISED BY THE ANSWER)

1. What is your child's normal bowel pattern?
   More than once a day ___ once a day ___ every other day ___
   2 - 3 times a week ___ less than 2-3 times a week ___
2. Does he/she ever strain or push forcefully to move their bowels? Yes___ No___
3. Does he/she ever have problems with constipation? Yes___ No___
4. Does he/she have staining/soiling of their underwear with stool? Yes___ No___
   If yes, how often? _____
5. Has he/she had blood in their stool or blood stained toilet paper? Yes___ No___
6. Does he/she complain of stomach pain that is relieved after having a bowel movement?
   Yes___ No___

Please circle type of stool that is most common for your child:

Bristol Stool Chart



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VOIDING/STOOL DIARY

Please mark:
"V" for each void (pee)
"A" for urine accident
"BM" for bowel movement and mark type number
"S" for bowel accident

date:	day 1 _ _/_ _/_ _	day 2 _ _/_ _/_ _	day 3 _ _/_ _/_ _	day 4 _ _/_ _/_ _	day 5 _ _/_ _/_ _
7am					
8					
9					
10					
11					
12 noon					
1pm					
2					
3					
4					
5					
6					
7					
8					
9					
10					
overnight					

Type 1 — Separate hard lumps (hard to pass)

Type 2 — Sausage-shaped but lumpy

Type 3 — Like a sausage but with cracks on its surface

Type 4 — Like a sausage or snake, smooth and soft

Type 5 — Soft blobs with clear-cut edges (passed easily)

Type 6 — Fluffy pieces with ragged edges, a mushy stool

Type 7 — Watery, no solid pieces, entirely liquid

Thank you for taking the time to complete this questionnaire.
PLEASE REMEMBER TO BRING THIS QUESTIONNAIRE WITH YOU