Pediatric Specialists of Virginia
Division of Urology Ambulatory Treatment Record
WISH Follow Up Patient Questionnaire, Page 1 of 2

PATIENT INFORMATION

Child's First Name: _____ Child's Sex: ☐ Male ☐ Female

Child's Last Name: _____

Child's Birth Date: _____ Child's Age: _____

REVIEW OF SYMPTOMS

Check all symptoms that your child has.

General	No	Yes
Fever	☐	☐
Tiredness	☐	☐

Heart	No	Yes
High Blood Pressure	☐	☐
Heart Murmur	☐	☐

Ear, Nose, Throat	No	Yes
Ear Infections	☐	☐
Sinus Problems	☐	☐

Joints	No	Yes
Scoliosis	☐	☐
Joint Pain	☐	☐

Skin	No	Yes
Eczema	☐	☐
Rashes	☐	☐

Lungs	No	Yes
Wheezing/Cough	☐	☐
History of Asthma	☐	☐

Nerves	No	Yes
Seizures	☐	☐
Developmental Delay	☐	☐
Headache or Migraines	☐	☐
Autism	☐	☐
ADHD Attention Deficit	☐	☐

Stomach / Intestines	No	Yes
Vomiting / Nausea	☐	☐
Abdominal Pain	☐	☐
Feeding Problems	☐	☐
Constipation	☐	☐
Stool Accidents	☐	☐

Hormone / Endocrine	No	Yes
Diabetes	☐	☐
High Cholesterol	☐	☐

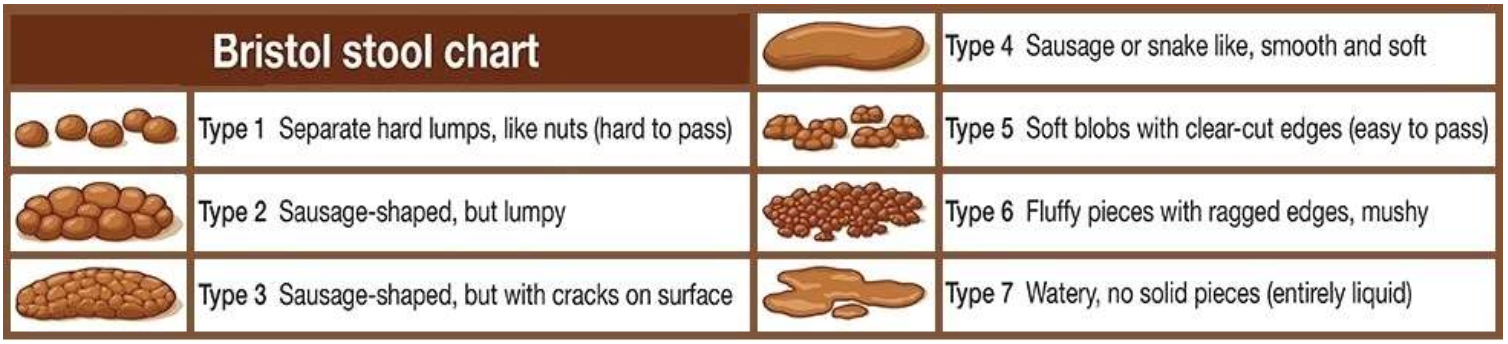
Eye	No	Yes
Vision Problems	☐	☐

URINARY TRACT INFECTIONS

1. Has your child ever had a urinary tract infection (UTI)? ☐ Yes ☐ No
2. At what age was his/her first infection? _____
3. How many UTI's does your child have per year? ☐ Only 1 ☐ 1 Or 2 ☐ 3 Or 4 ☐ Greater Than 4
4. What was the date of his/her last UTI? _____
5. Which symptoms did he/she have with the UTI?
   - ☐ Wetting
   - ☐ Frequent Urination
   - ☐ Painful Urination
   - ☐ Nausea/Vomiting
   - ☐ Fever Over 100 Degrees
   - ☐ Strong Urge to Void
   - ☐ Foul Smelling Urine
   - ☐ Abdominal/Back Pain
6. Did the UTI occur while your child was on an antibiotic? ☐ Yes ☐ No
7. If yes, what antibiotic was he/she taking when the UTI occured? _____
8. Does your child have urinary reflux? ☐ Yes ☐ No ☐ Don't Know
9. Is there a family history of urinary reflux? ☐ Yes ☐ No ☐ Don't Know

BOWEL MOVEMENTS / STOOLING / POOPING HABITS

1. Look at the pictures and descriptions in the Bristol stool chart; circle the type of bowel movement that your child has most often: 1 | 2 | 3 | 4 | 5 | 6 | 7



Please continue answering questions on the back.

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IOWA PEDIATRIC BLADDER & BOWEL DYSFUNCTION QUESTIONNAIRE

Circle your answers to the following questions:	0	1	2	3	4
1. During the day, I wet my clothes or underwear	Never	Less than once a week	About once a week	About once a day	More than once a day
2. To keep from peeing I cross my legs, squat, or do the 'PP dance'	Never	Less than once a week	About once a week	About once a day	More than once a day
3. It hurts when I pee	Never	Less than once a week	About once a week	About once a day	More than once a day
4. I have to push or strain to make the pee come out	Never	Less than once a week	About once a week	About once a day	More than once a day
5. I wait until the last second to go to the bathroom to pee	Never	Less than once a week	About once a week	About once a day	More than once a day
6. When I have to pee I cannot wait or I may wet my clothes or underwear	Never	Less than once a week	About once a week	About once a day	More than once a day
7. When I am finished peeing, I feel like I have to pee some more	Never	Less than once a week	About once a week	About once a day	More than once a day
8. I wet myself suddenly without the feeling that I need to pee	Never	Less than once a week	About once a week	About once a day	More than once a day
9. I only pee 1-3 times a day	Never	Less than once a week	About once a week	A few times a week	Daily
10. I leak pee when I sleep at night	Never	Less than once a week	About once a week	About once a day	Each night
11. I wear diapers or pull ups at night	Never	Less than once a week	About once a week	A few times a week	Every night
12. How often do you poop?	At least once a day	Every other day	Once every few days	Once a week	Less than once a week
13. It hurts when the poop comes out	Never	Rarely	Sometimes	Most of the time	Always
14. I have to push hard or strain to make the poop come out	Never	Rarely	Sometimes	Most of the time	Always
15. My poop is so big it clogs the toilet	Never	Rarely	Sometimes	Most of the time	Always
16. My poop is hard and little, like small rabbit pellets	Never	Rarely	Sometimes	Most of the time	Always
17. I have poop accidents	Never	Less than once a week	About once a week	About once a day	More than once a day
18. Some children are embarrassed, feel anxious, or don't do things with friends because of pee or poop problems. How big of a problem is this for you in the last month?	No problem	Very small problem	Small problem	Medium problem	Big problem

Thank you for completing this questionnaire.

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