

David C. Saypol, M.D., M.S., F.A.C.S.
 Arthur R. Israel, M.D., F.A.C.S.
 David C. Chaikin, M.D., F.A.C.S.
 Perry M. Sutaria, M.D., F.A.C.S.
 Lee B. Pressler, M.D., F.A.C.S.
 Eric K. Seaman, M.D., F.A.C.S.

Michele R. Clement, M.D.*
 * Pediatric Urology

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261 James Street, Suite 1A
 Morristown, NJ 07960
 973.539.1050
 Fax 973.538.6111
www.muaj.com

95 Madison Avenue, Suite 302
 Morristown, NJ 07960
 973.656.0600
 Fax 973.656.0200

Date: _____

Name: _____

Birthdate: _____ Acct #: _____

Reason for being seen:

Does your child have a history of wetting?

Daytime	YES	or	NO
Nighttime	YES	or	NO

DAYTIME WETTING:

How many days a week does your child have daytime wetting? Please circle one response.

1. Less than three days a week
2. Between three and six days a week
3. Everyday

When your child wets, does he/she usually? Please circle one response.

1. Needs to change their clothing
2. Dampens their underwear
3. Just "leaks"

How long has your child had daytime wetting? Please circle one response.

1. Since attempting to toilet train
2. More than twelve months
3. Under twelve months

NIGHTTIME WETTING:

If your child has nighttime wetting, please estimate episodes per week.

1. Less than three nights a week
2. Between three and six nights a week
3. Every night

When your child wets at night does he/she? Please circle one response.

1. Soak the sheets
2. Dampen the sheets
3. Dampen their pajamas

Does your child wear pull-ups or diapers at night? YES or NO

How long has your child had nighttime wetting? Please circle one response.

1. Since attempting to toilet train
2. More than twelve months
3. Under twelve months

Does your child have a history of urinary tract infections? YES or NO

If yes, does your child experience any of these symptoms? Please circle one response.

1. Burning upon urination
2. Urinating frequently and/or urgency to urinate (void)
3. Foul smell of urine
4. Day or night time wetting only when infected
5. Fever of 101°
6. Other: _____

TOILETING HABITS:

How long can your child wait after feeling the need to go to the bathroom?
Please circle one response.

1. Can't wait, runs to the bathroom
2. Waits ten to twenty minutes
3. Tries to delay indefinitely
4. Uncertain

How many times in twenty-four hours does your child go to the bathroom to void?
Please circle one response.

1. Less than four
2. Between five and seven
3. Over seven

Does your child have certain rituals to avoid wetting during the day such as squatting, dancing, or grabbing? YES or NO

Is your child's urinary stream? Please circle one response.

1. Continuous (steady)
2. Interrupted (stop/start)
3. Unknown

Will your child go to the bathroom when requested to? Please circle one response.

1. Always
2. Sometimes
3. Never

At what age was your child trained for urine?

Day _____ Night _____ Can't remember _____

At what age was your child trained for B.M.?

_____ Can't remember _____

Does your child have? Please circle one response.

1. Normal bowel movements
2. Large, hard painful to pass bowel movements
3. Bowel movements or staining in their underwear

How often does your child have bowel movements? Please circle one response.

1. Daily
2. Every other day
3. Every three to four days
4. Once a week

Has your child's bowel movements changed in the last six months? YES or NO

If yes, please explain:
