PENNSTATE HERSHEY
Milton S. Hershey Medical Center

Dear Parents:

Welcome to the Pediatric Dysfunctional Voiding Clinic at the Hershey Medical Center. This special clinic is designed to help children and parents discuss and deal with daytime and nighttime wetting problems

Our clinic is located on the third floor of the University Physician Center II in Suite 3100. Please park in the University Physician Center parking lot and use the entrance for the University Physician Center II. Please arrive 15 minutes prior to your appointment time to complete the registration process and pre-visit studies. (See below).

It is very important to complete the enclosed questionnaire and 3-Day Voiding Diary and bring them with you to the appointment. Depending on your child's issues, the following studies may be done as part of the clinic visit:

-KUB, an x-ray including the kidneys, bowel, and spine
-Urinalysis
-Post-void residual urine by ultrasound

Your child should come to the appointment with a full bladder. He/she may eat and drink normally prior to the above studies.

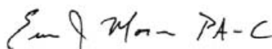
Voiding problems are common in children and, as you are probably aware from the scheduling process, the Voiding Dysfunction Clinic has a very full schedule. Unfortunately, the rate of missed appointments has also been very high. If it will be necessary for you to miss your appointment, we strongly request that you call the clinic as early as possible to cancel so that another patient can be scheduled (717-531-8887). Missed appointments contribute highly to our backlog. Therefore, we have been forced to implement the following policy:

> ***Patients who miss their originally scheduled appointment without calling to cancel can be rescheduled for the next available appointment (which may be several months in the future.) We will not add extra appointments to make-up missed appointments. Patients who miss two consecutive appointments (new or return), without calling to cancel, will not be rescheduled. If you miss a clinic visit without calling to cancel and feel that your child's circumstances necessitate an early rescheduled visit or believe that there are extenuating circumstances surrounding the missed visit, you may ask your primary care physician to call Erin J. Moran, PA-C to reschedule the appointment.***

If you have an HMO and need a referral from your primary care physician, please bring the referral with you at the time of the appointment. **If x-rays or studies have been done, be sure to bring them with you to the appointment.**

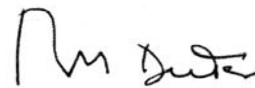
If you have any question, please feel free to call Erin J. Moran, PA-C at 717-531-8848.

Sincerely,



Erin J. Moran, PA-C
Urology

Karen R. Thompson, CRNP
Urology



Ross M. Decter, M.D.
Chief, Division of Urology

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VOIDING DIARY QUESTIONNAIRE

Bladder and Bowel Assessment

1. What type of problem is your child having? ______________________________

____

2. Has your child been treated for this problem? ☐ yes ☐ no

If yes, how was the problem treated? ______________________________

____

3. Has your child had any tests to further evaluate his/her problem? ☐ yes ☐ no

If yes, what tests were carried out? ______________________________

____

____

*If tests were carried out, please be sure to bring the films to the appointment so that they may be reviewed.

4. Has your child ever had surgery on his/her bladder or bowel? ☐ yes ☐ no

If yes, what was done? ______________________________

____

5. Name and dose of your child's current medications: ______________________________

____

____

Allergies: ______________________________

____

____

6. At what age did toilet training start?______________________________

At what age did your child control his/her bowel movements? ______________________________

At what age was daytime urinary control obtained?______________________________

At what age was nighttime urinary control obtained? ______________________________

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VOIDING DIARY QUESTIONNAIRE

7. Has your child experienced any of the following:
   - Pain with urination ☐ yes ☐ no
   - Need to void urgently (in a hurry) ☐ yes ☐ no
   - Urinating frequently ☐ yes ☐ no
   - Frequent nighttime urinating ☐ yes ☐ no
   - Frequent urinating before falling asleep ☐ yes ☐ no
   - Frequent daytime urinating ☐ yes ☐ no
   - Excessive thirst ☐ yes ☐ no
   - Dribbling stream when urinating ☐ yes ☐ no
   - Visible blood in urine ☐ yes ☐ no
   - Daytime wetting before going to the toilet ☐ yes ☐ no
   - Daytime wetting after going to the toilet ☐ yes ☐ no
   - Wetting without trying to get to the toilet ☐ yes ☐ no
   - Lack of awareness he/she is urinating ☐ yes ☐ no
   - Dribbling after urinating ☐ yes ☐ no
   - Avoidance of toilets away from home/school ☐ yes ☐ no

8. Do you notice any special behavior before or after your child wets his/her pants? ☐ yes ☐ no
   If yes, what type of behavior? (example – squatting, holding his/herself, etc.) ____________________

9. Has your child ever had a urinary tract infection? ☐ yes ☐ no
   If yes, how often? ☐ once or twice a year ☐ several times a year
   When did infections begin?____________________

10. If your child has had a urinary tract infection, what type of symptoms does he/ she usually have?
    ☐ burning with urination ☐ frequent urination ☐ fever ☐ nausea ☐ urgency ☐ malaise

11. Does your child wet the bed? ☐ yes ☐ no
    If yes, how often? ☐ daily ☐ several times a week ☐ several times a month

12. Is there a family history of bed-wetting? ☐ yes ☐ no
    Who, and what age did they stop wetting the bed?____________________

13. How often does your child pass his or her bowels?
    ☐ every day ☐ every other day ☐ less often
    If less often, how often? ____________________

14. Do you think your child is constipated? ☐ yes ☐ no

15. Does your child complain of pain when having a bowel movement? ☐ yes ☐ no

16. What best describes your child's bowel movement?
    ☐ liquid ☐ soft ☐ formed ☐ hard balls
    Amount? ☐ small ☐ medium ☐ large

17. Does your child ever soil his/her underwear? ☐ yes ☐ no
    If yes, how often? ☐ daily ☐ weekly ☐ monthly ☐ less often

18. Does your child ever need to take a laxative? ☐ yes ☐ no
    If yes, what does your child take and how often? ____________________

____

VOIDING DIARY QUESTIONNAIRE

19. Has your child ever been treated by a doctor for constipation? ☐ yes ☐ no

    If so, what was the treatment? ____

    ____

    ____

20. Describe any problems with physical, brain, or reflex development. ____

    ____

    ____

21. Describe any behavioral or emotional problems. ____

    ____

    ____

22. Tell us about any problems at school or at home. ____

    ____

    ____

23. What treatment, if any, has been used to help with urine control? ____

    ____

    ____

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VOIDING DIARY QUESTIONNAIRE

Three-Day Voiding Diary

	Day 1	Day 2	Day 3
6:00 a.m.			
7:00 a.m.			
8:00 a.m.			
9:00 a.m.			
10:00 a.m.			
11:00 a.m.			
12:00 noon			
1:00 p.m.			
2:00 p.m.			
3:00 p.m.			
4:00 p.m.			
5:00 p.m.			
6:00 p.m.			
7:00 p.m.			
8:00 p.m.			
9:00 p.m.			
10:00 p.m.			
11:00 p.m.			
12:00 midnight			
1:00 a.m.			
2:00 a.m.			
3:00 a.m.			
4:00 a.m.			
5:00 a.m.			

KEY

U = planned urination, measure volume if possible

BM = bowel movement **A** = urinary accident **FS** = fecal soiling

Signature:______________________________ Date:________________ Time:______________