SWEDISH PEDIATRIC SPECIALTY CARE

Bowel and Bladder Program

Welcome and thank you for choosing the Swedish Pediatric Specialty Care's Bowel and Bladder Program. Our goal is to help you and your child solve any voiding (peeing) problems he/she may be dealing with.

To help us better understand your child's elimination problem, it is important that you complete the following and bring it with you to your appointment or fax it to us before your appointment:

- **Voiding history:** This gives us some background on your child's health and voiding problems.
- **The Elimination Diary**
  INSTRUCTIONS:
  - **Voiding:** You can do this any days during the week or on the weekend just as long as it's done for two days. Please don't prompt your child to go to the bathroom when you fill this out. Please record what time you child pees and also the total daily volume of fluids consumed that day and what he/she drank.
  - **Bowel movements:** We need to know how often your child has a bowel movement (BM) in one week and what number (in the stool chart) it looks like.
- **PLUTSS score:** This gives us a "snapshot" of how often symptoms happen in the past 30 days.

Your child will have a comprehensive evaluation which may include the following tests if needed:

- **Urinalysis** – to look for any infection or other health issues
- **Uroflow** – your child will pee into a "special toilet" to measure how well the bladder works
- **Post void residual** – this involves a small amount of gel on the lower abdomen to measure how well the bladder can empty
- **KUB** – an abdominal X-ray to evaluate for anything pushing on your child's bladder
- **Ultrasound of kidneys/bladder** – to look for any structural problems

If you should have any questions, please give us a call.

Thank you and we look forward to meeting you.

SWEDISH PEDIATRIC SPECIALTY CARE
Pediatric Urology
Contact: 206-215-2700
Fax: 206-215-2702

It's important your child arrives to the clinic with a full bladder.

Please visit our website for more information:
https://www.swedish.org/services/pediatric-specialty-care/our-services/pediatric-bowel-and-bladder-care

SWEDISH PEDIATRIC SPECIALTY CARE

Elimination (Voiding and Bowel Movement) Diary

For one week, chart when you have a BM and what it looks like:

	Did you poop today?	What type did it look like? (see chart below)	Did it hurt to poop?
Monday	YES / NO		YES / NO
Tuesday	YES / NO		YES / NO
Wednesday	YES / NO		YES / NO
Thursday	YES / NO		YES / NO
Friday	YES / NO		YES / NO
Saturday	YES / NO		YES / NO
Sunday	YES / NO		YES / NO

Choose your poop!	What's it look like?	
TYPE 1		**Rabbit droppings** Separate, hard lumps, like nuts (hard to pass)
TYPE 2		**Bunch of grapes** Sausage-shaped but lumpy
TYPE 3		**Corn on cob** Like a sausage but with cracks on its surface
TYPE 4		**Sausage** Like a sausage or snake, smooth and soft
TYPE 5		**Chicken nuggets** Soft blobs with clear-cut edges (passed easily)
TYPE 6		**Oatmeal/mashed potatotes** Fluffy pieces with ragged edges, a mushy stool
TYPE 7		**Gravy** Watery, entirely liquid

For two days, mark down what time you went pee:

DAY 1	DAY 2

List the types of fluids you drank and how much:

DAY 1	DAY 2

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

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Voiding History

Please answer the following questions to help us better evaluate your child's voiding problem(s).

MAIN CONCERN FOR VISIT: _____

_____

At what age did your child START toilet training? _____ NOT YET

At what age did your child start to STAY DRY DURING THE DAY? _____ NOT YET

At what age did your child start to STAY DRY AT NIGHT? _____ NOT YET

If your child achieved dryness, did he/she stay dry for a six-month period? YES NO

If yes, please circle: DAYTIME NIGHTTIME BOTH

VOIDING/ELIMINATION:

Are there wetting accidents? YES NO If yes, please circle: DAYTIME NIGHTTIME BOTH

Do you see urgency with urination? YES NO SOMETIMES

Do you see your child doing the "potty dance" or holding maneuvers? YES NO SOMETIMES

If your child has daytime wetting accidents, do they happen during play/screen time? YES NO

Does your child have wetting accidents ONLY when giggling or laughing? YES NO

Does your child have wetting accidents (or dribbling) AFTER he/she is done urinating? YES NO

Does your child have any stool marks or streaking in their underwear? YES NO

Does your child have encopresis (stooling accidents)? YES NO

BLADDER/KIDNEY INFECTIONS:

Has your child had any bladder infections? YES NO

- At what age was the first one? _____
- How many bladder infections has he/she had so far? _____
- How many have there been in the past year? _____

Has your child had kidney infections (bladder infection with a high fever)? YES NO

- If YES, how old was your child when he/she had the first one? _____
- Was he/she hospitalized? YES NO
- When was the last one? _____
- Is your child on a small daily dose of an antibiotic to try to prevent another one? YES NO

FAMILY HISTORY:

Is there a family history of kidney, bladder or voiding problems? YES NO

If YES, please explain: _____

_____

Has anyone in the family had problems with bedwetting? YES NO

If YES, please tell us who and at what age it resolved? _____

PREGNANCY/BIRTH HISTORY:

Were there any problems with any prenatal ultrasounds? YES NO

If YES, please explain: _____

_____

Was your child born: ON TIME PRETERM LATE C-SECTION FORCEPS/SUCTION

Were there any complications/problems after birth? YES NO

If YES, please explain: _____

_____

GROWTH AND DEVELOPMENT:

Did your child have any delays in growing up and developing? YES NO

If YES, please explain: _____

_____

Does your child have a history of any neurological problems? YES NO

If YES, please explain: _____

_____

Does your child have any of the following? YES NO If YES, please circle:
ADD/ADHD OCD ODD ANXIETY AUTISM/ASD SENSORY INTEGRATION PROBLEMS

SOCIAL:

Have there been any adverse, difficult or stressful events in your child's life? YES NO

If YES, circle below:

- Relocation/move in the last two years
- Multiple moves
- Divorce
- Adoption/foster care/new baby
- Death in family
- Family member incarcerated
- Witness or experience abuse/violence
- Witness or exposure to alcohol or drug abuse
- Other: _____

PREVIOUS TREATMENTS/THINGS YOU'VE TRIED:

Please list things you've tried in the past, if they helped or not and what, if anything, you are currently doing for management.

_____

_____

_____

_____

_____

_____

_____

PEDIATRIC LOWER URINARY TRACT SCORING SYSTEM (PLUTSS)

INSTRUCTIONS: These questions should be answered by your child. Help them look back at the last 30 days.

Over the last month (30 days)	Almost never	Less than half the time	About half the time	Almost every time	N/A
I have had wet clothes or wet underwear during the day	0	1	2	3	N/A
When I wet myself my underwear is soaked	0	1	2	3	N/A
I skip a day or more between bowel movements (pooping)	0	1	2	3	N/A
I have to push for my bowel movements (poop) to come out	0	1	2	3	N/A
I only go to the bathroom (to pee) one or two times all day	0	1	2	3	N/A
I hold onto my pee by crossing my legs, squatting down or doing the "pee dance"	0	1	2	3	N/A
When I need to pee, I cannot wait	0	1	2	3	N/A
When I pee, it starts and stops a few times	0	1	2	3	N/A
I have to push or wait a while for my pee to start	0	1	2	3	N/A
When I pee it hurts	0	1	2	3	N/A

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