SDC - BBD CLINICIAN ASSESSMENT FORM

Patient Label

What are your main concerns or what is your understanding for this referral?

URINARY HISTORY

Are there any problems with your child's urination? Known kidney or urinary disease?

At what age was your child toilet trained?

Not trained ☐ Urine (day): _____ Urine (night): _____ Stool: _____

How many times are they urinating during the day?

Wake-up	Mid-Morning	Lunch	Mid-Afternoon	Dinner	Evening	Bedtime

Lower Urinary Tract Symptoms

Frequency	☐ Yes ☐ No	Urgency	☐ Yes ☐ No	Straining	☐ Yes ☐ No
Dribbling	☐ Yes ☐ No	Dysuria	☐ Yes ☐ No	Withholding	☐ Yes ☐ No
Postponing	☐ Yes ☐ No	Hematuria	☐ Yes ☐ No		

Urinary Tract Infections:

Frequency: _____ Febrile UTI ☐ Yes ☐ No

Collection: ☐ Midstream Urine ☐ Bag Specimen ☐ Urine Catheter

Daytime Incontinence: ☐ Yes ☐ No

Onset:_____ Frequency: _____times/day _____days/week

Severity: ☐ Damp underwear ☐ Wet through outer clothes ☐ Puddle

When does the wetting primarily occur?

Prior to voiding	☐ Yes ☐ No	Associated with exercise	☐ Yes ☐ No
After voiding	☐ Yes ☐ No	Associated with laughing	☐ Yes ☐ No
Randomly	☐ Yes ☐ No	Other: _____	

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Nocturnal Enuresis: ☐ **Yes** ☐ **No**

Onset:_____ Frequency: _____days/week

Has your child ever been dry at night for more than 6 months? ☐ Yes ☐ No

Past treatment: _____

DVSS Score (Please refer to Patient Intake Form): _____

CONSTIPATION

Tell me about your child's stooling habits/routine. Any history of constipation?

Frequency of stool: _____times/day _____days/week Bristol Stool Type (1-7): _____

Amount of time it takes to have a bowel movement: _____minutes

Associated symptoms with STOOLING?

Abdominal or rectal pain	☐ Yes ☐ No	Withholding behavior	☐ Yes ☐ No
Large caliber stool	☐ Yes ☐ No	Strains to have a stool	☐ Yes ☐ No
Blood in stool or on paper	☐ Yes ☐ No	Nausea/vomiting	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Perineal rash/fissure	☐ Yes ☐ No

Encopresis (soiling)? ☐ Yes ☐ No

Onset:_____ Frequency: _____times/day _____days/week

Severity: ☐ Stains in pants or on pad ☐ Modest amount ☐ Full bowel movement

Past Treatments:

Treatment	Dose?	Success?	Treatment	Dose?	Success?
PEG 3350		☐ Yes ☐ No	Senna		☐ Yes ☐ No
Enemas		☐ Yes ☐ No	Lactulose		☐ Yes ☐ No
Mineral oil		☐ Yes ☐ No	Other		

Red flags:

Recurrent fevers or frequent infections ☐ Yes ☐ No
Weight loss or poor weight gain ☐ Yes ☐ No
Weakness in arms/legs ☐ Yes ☐ No
Numbness in the peeing or pooing area ☐ Yes ☐ No
Always thirsty and drinks an excessive amount of water ☐ Yes ☐ No

Other: _____

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DIET/FLUID HISTORY (Please refer to Patient Intake Form):

PAST MEDICAL HISOTRY:

Birth History:

Passage of meconium in first 24 hours: ☐ Yes ☐ No

Medications: _____

Allergies: _____

Immunizations up to date: ☐ Yes ☐ No

Medical History:

Hospitalizations or surgeries:

Has there been any developmental or behavioural concerns?

FAMILY HISTORY:

PSYCHOSOCIAL HISTORY:

Education: ☐ Daycare/Kindergarten ☐ Grade:_____ ☐ Other: _____

Family: Married ☐ Divorced ☐ Separated ☐ Single ☐ Reconstituted ☐

Safety: Bullying ☐ Yes ☐ No History of abuse ☐ Yes ☐ No

Have there been any of the following recent events in your child's life?

New home ☐ Yes ☐ No New school ☐ Yes ☐ No Recent divorce/separation ☐ Yes ☐ No

New baby ☐ Yes ☐ No Injury ☐ Yes ☐ No Death/Major illness ☐ Yes ☐ No

Please specify: _____

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PHYSICAL EXAM:

Weight:_____(Kg) (_____%) Height:_____(cm) (_____%)

Heart Rate:_____ Blood Pressure:_____

CVS:	Normal	/ abnormal	Specify:_____
Resp:	Normal	/ abnormal	Specify:_____
ENT	Normal	/ abnormal	Specify:_____
Skin	Normal	/ abnormal	Specify:_____

Abdominal distention ☐ Yes ☐ No Palpable fecal mass: Location_____
Pain_____

Rectal:
- ☐ Perianal erythema, skin tags, fissures
- ☐ Stool around anus or on clothes
- ☐ Anorectal malformation (position)

If digital rectal exam done:
- ☐ Tone and sensation (anal wink)
- ☐ Presence of stool, consistency
- ☐ Explosive stool on withdrawal of finger

GU (as applicable to sex):
- ☐ Rash / Bruising
- ☐ Labial adhesions
- ☐ Urethra, dorsal fat pad
- ☐ Circumcised
- ☐ Hypospadias or Epispadias
- ☐ Testes descended

Neuro/Musculoskeletal:
- ☐ Gait ☐ Coordination
- ☐ Spine sacral dimple / hair tuft / dermavascular malformation
- ☐ Limb strength Upper / Lower
- ☐ Deep tendon reflexes Upper / Lower

INVESTIGATIONS:

IMPRESSION:

PLAN:

FOLLOW-UP: