



# 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
- Large caliber stool  Yes  No
- Blood in stool or on paper  Yes  No
- Diarrhea  Yes  No
- Withholding behavior  Yes  No
- Strains to have a stool  Yes  No
- Nausea/vomiting  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:

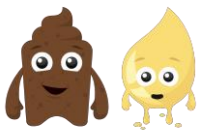
Treatment	Dose?	Success?
PEG 3350		<input type="checkbox"/> Yes <input type="checkbox"/> No
Enemas		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mineral oil		<input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment	Dose?	Success?
Senna		<input type="checkbox"/> Yes <input type="checkbox"/> No
Lactulose		<input type="checkbox"/> Yes <input type="checkbox"/> 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 HISTORY:

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: