

## Questions for all new patients

If a GP referral has been made, you will receive a full pack in the post including this questionnaire and a stamped addressed envelope.

You may wish to complete this questionnaire now to avoid any delays.

This questionnaire allows us to have an assessment of the problems prior to clinic and hopefully allow better allocation of time and services.

**Please go through these questions with your child.**

Name of Child .....

Date of Birth .....

Circle as appropriate

Have you provided your GP with a urine sample? Yes / No

If No please attend your GP to provide a urine sample for dipstick.  
Ask you GP surgery to dipstick the urine to screen for sugar and infection

Has your child always had problems with night-time wetting? Yes / No

If No has your ever child been dry for more than 6 months? Yes / No

Does your child have a problem with day-time wetting? Yes / No

If **Yes** please complete the day-time urine volume chart before attending clinic. Please continue with the questionnaire.

If **No** at what age were they dry by day .....

Does your child suffer with Urinary Tract Infections?

Previous urine infection? Yes / No

Pain with passing urine? Yes / No

Frequency or urgency? Yes / No

If **Yes** to the above questions, please ensure your GP has reviewed the possibility of a urine infection and we will follow this up in our clinic. Please continue with the questionnaire.

Does your child suffer with Constipation?

Infrequent hard stools? Yes / No

Pain with passing stool? Yes / No

Blood on toilet paper? Yes / No

If **Yes** consider discussing this with your GP. Please continue with the questionnaire.

Does your child suffer with excessive thirst and drinking?

Does your child drink excessively during the day? Yes / No

Does your child need a drink in the middle of the night? Yes / No

**Birth**

Where was your child born? .....

How much did they weigh? .....

Circle as appropriate

Was your child admitted to Special Care?  
If **Yes** please give a few brief details

Yes / No

**Development**

How old was your child when they first walked? .....

Are there any concerns with your child's development?  
If **Yes** please give a few brief details

Yes / No

**Medical Problems**

Has your child had any operations or significant accidents?  
If **Yes** please give a few brief details

Yes / No

Does your child have any of the below problems?

Attention Deficit Hyperactivity Syndrome (ADHD)

Behavioural problems

Disturbed sleep

Yes / No

Yes / No

Yes / No

Does your child snore at night?

If **Yes** do they complain of tiredness in the day?

Yes / No

Yes / No

A few questions about your family household and schooling

**Mother**

Name.....

Occupation.....

Suffered with night-time wetting as a child? Yes / No

If **Yes** how old when resolved?.....

**Father**

Name.....

Occupation.....

Suffered with night-time wetting as a child? Yes / No

If **Yes** how old when resolved?.....

Circle as appropriate

Married / Divorced / Cohabiting

**Other Adults in the Household**

Name.....

Relationship.....

Name.....

Relationship.....

**Brothers/Sisters**

Please could you give some details of your other children including any medical problems they may have?

	Name	Age	Medical Problems?
1			
2			
3			
4			
5			

**About your childs bedroom**

Circle as appropriate

- Does your child share a room? Yes / No
- Does your child sleep in bunk-beds? Yes / No
- Are the toilets on the same floor as the bedroom with easy access? Yes / No

**School**

- What School does your child attend? .....
- Are there any learning problems? Yes / No  
If **Yes** please explain

- Are there any other problems at school? Yes / No  
If **Yes** please explain

If you have any other comments please use the space below.

Thank you for completing the above form.

Please return to:-  
Enuresis Clinic,  
Department of Child Health,  
Salisbury District Hospital,  
Salisbury,  
SP2 8BJ.