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NOCTURNAL ENURESIS QUESTIONNAIRE

Nocturnal enuresis means urinating, wetting or “peeing” in the bed at night. Your answers to the following questions about this problem will help me to understand how best to help you with it.

These questions are about you, the patient. Parents or guardians and children/adolescents can complete this form together. Circle, check or write in the answer that best tells about you.

Young person’s name _____

Preferred or nickname _____

Special pronunciation _____

Birth date _____ Today’s date _____

Person helping to complete this form _____

1. How old were you when you started urinating in the toilet during the day?
_____ years
2. How many nights each week do you *usually* stay dry? 0 1 2 3 4 5 6
3. What is the longest you have ever been dry every night in a row? (Write in a number.)
a. _____ Days b. _____ Weeks c. _____ Months
4. Please *check* any and all of the following ways you have ever used to stay dry at night.
Circle any of them you are using now.

___ Diaper or “Pull-up”

___ Hypnosis

___ Drinking little or less after dinner

___ Keeping “Dry Night” calendar

___ Alarm Clock wakes at night

___ Parent wakes at night

___ Accupuncture/Accupressure

___ Punishment for wet nights

___ Trying to remember to keep dry

___ Rewards for dry nights

___ Enuresis Alarm (Device that makes noise/vibrates when wet): _____

Brand Name of Device

5. Have you ever used any of these medicines to treat enuresis? (Check all that apply)

- Imipramine (Tofranil) Dose: _____
- Desmopressin (DDAVP) Dose: _____
- Oxybutinin (Ditropan) Dose: _____
- Homeopathic medicine
- Herbal Substance: _____
- Other: _____

6. Do you sometimes drink caffeinated drinks (soda, tea, coffee) during or after dinner?
Yes No

7. When you need to urinate during the day, do you have to go right away? Yes No

8. Do you sometimes urinate in your clothes by accident during the day? Yes No

If "Yes" how many times each week? 1 2 3 4 5 6 7 more than 7

9. Do you sometimes have a bowel movement (BM, "poop") in your clothes by accident during the day? Yes No

If "Yes" how many times each week? 1 2 3 4 5 6 7 more than 7

10. Is it hard for you to have a bowel movement most days? Yes No

11. Do you take any medicine to help you have bowel movements most days? Yes No

If "Yes," what medicine(s)? _____

12. Do you have any other medical or health problems? Yes No

If "Yes," please check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Learning problems | <input type="checkbox"/> Bladder infections |
| <input type="checkbox"/> Attention Deficit Disorder (ADD, ADHD) | <input type="checkbox"/> Allergies: to what? |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Something else: |

13. Do you take any other medicines? Yes No

If "Yes," what medicine(s): _____

14. Did either of your parents, or any uncles, aunts or cousins have enuresis as a child?

Yes No

If "Yes," who:

___ Mother

___ Aunt (Mother's Side)

___ Father

___ Uncle (Mother's Side)

___ Sister

___ Aunt (Father's Side)

___ Brother

___ Uncle (Father's Side)

___ Cousin

15. Is enuresis a problem for you? Yes No

If "Yes," check all reasons why it is a problem that fit for you, circle the most important one.

___ Can't do sleep-overs

___ Parents are upset

___ Embarrassing on vacations

___ Don't like wearing diapers

___ Have to wash my sheets/pajamas a lot

___ Can't get a new bed

___ Getting teased

___ Don't feel good about myself

___ Something else: _____

Thank you for answering these questions. If there is more you want us to know, please write it here. If there are questions you want to make sure we answer for you, please write them here. You can also draw a picture if you like (there is more room on the back).