Cardinal Glennon
SSM Cardinal Glennon Children's Medical Center

Child's Name: ____

PERSONAL HABIT QUESTIONAIRE (4 pages)

(Complete all that apply)

Urinary habits

- Wet daytime _____ times per day
- Wet nighttime _____ nights per week
- Empties his/her bladder _____ times per day
- Urgency _____times per day/week/occasional (circle frequency)
- Dribbling/wet pants _____times per day
- Positioning (crosses legs, sits on heel, potty dances etc.) when he/she needs to empty his/her bladder
- Sound/size of stream
    - full like a hose
    - tinkling/dribble
    - tight like a squirt gun
- Placement of stream
    - always hits the water/stays in the toilet
    - stream goes or shoots up, to the left, to the right, backwards or straight out of the toilet (circle the direction of the stream)
- Urinary tract infections x _______
    - proven by culture. Yes/no (circle one)
- Chocolate intake _____times per day/week/occasional (circle frequency)
- Caffeine intake _____times per day/week/occasional (circle frequency)
- List all medications he/she is taking:

(Next page for bowel habits)

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Bowel habits

- Size and shape of BMs (circle all that apply)
    - Peas, marbles, grapes, golf balls, tennis ball, baseball
    - Long banana shaped as wide as 1, 2, 3, 4 or more fingers wide
- Soils underwear _____ times per day or week
- Frequency of BMs _______ times per week
- Complaints of abdominal pain
- Pain associated with passing BMs
- Blood on or in BMs
- Gets full easily while eating
- Increased gas passage
- Intermittent diarrhea and hard stools

(Next page for sleep habits)

Sleep habits (circle all that apply)

Snoring, heavy or loud breathing	yes	no
Over extension of neck during sleep	yes	no
Movement arousals, restless sleep	yes	no
Difficult to wake up	yes	no
Doesn't remember awaking	yes	no
(if woken up to void urine or bowel)		
Walks in sleep	yes	no
Growing pains	yes	no
Restless legs/tingling	yes	no
Gasping for breath	yes	no
Wakes up with dry mouth/throat, drools or mouth breathes	yes	no
Drowsiness during the day, naps or teacher reports that he/she appears sleepy	yes	no
Period of snoring, then no sound, "snorting"	yes	no
Urinates in the bed	yes	no
Urinates in unusual places (ie. tub, trashcan, fireplace) unaware of doing this	yes	no
Falls asleep on car rides (not long trips)	yes	no
Hyperactive	yes	no
Memory problems	yes	no

Gets in trouble at school or home	yes	no
Mood issues	yes	no
Sweating during sleep	yes	no
Choking during sleep	yes	no
Talking during sleep	yes	no
Nightmares	yes	no
Grinds teeth	yes	no
Difficulty falling asleep	yes	no
Difficulty staying asleep	yes	no
Feels rested/refreshed when getting up	yes	no
ADD/ADHD	yes	no
Takes more than 30 minutes to fall asleep	yes	no
Slow rate of growth	yes	no
Morning headache	yes	no
Overweight or obese	yes	no

(End)