

**Please complete this diary on 4 days, when the child is with you all day, such as a weekend or holiday.**

**Do NOT complete on school days.**

**Return this form at your child’s next visit. Failure to complete this diary could result in your child’s appointment being rescheduled.**



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Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Toileting Diary**

Please complete this diary as follows:

-**Start** this diary, after receiving this form, on days when the child will be home with you.

-Make an “X” for each urination in the “**Urine**” column.

-Include urine volumes in the “**Volume**” column only if given a urinal/hat.

-Make an “X” for each urinary accident in the “**A**” column.

-Make an “X” for each bowel movement in the “**BM**” column.

-Make an “X” for each bowel accident in the “**S**” column.

-Mark the overnight column “**Wet**” or “**Dry**” based on how they wake up that morning.

**RETURN THIS FORM AT YOUR CHILD’S NEXT VISIT*.***

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| **Day 1** | Date:  |   |   |   |   |  | **Day 2** | Date:  |   |   |   |   |
| Time | Urine | Volume | A | BM | S |  | Time | Urine | Volume | A | BM | S |
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| Overnight: Wet or Dry (circle one) |   |   |  | Overnight: Wet or Dry (circle one) |   |   |

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Day 3 | Date:  |   |   |   |   |  | Day 4 | Date:  |   |   |   |   |
| Time | Urine | Volume | A | BM | S |  | Time | Urine | Volume | A | BM | S |
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| Overnight: Wet or Dry (circle one) |   |   |  | Overnight: Wet or Dry (circle one) |   |   |

Anything additional that we should be aware of:

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**CUPID: Center for Urology and Pediatric Incontinence Disorders**

 **Ahmad Z Mohamed, MD Ezekiel Young, MD Allyson Fried, CPNP Sabrina Meyer, CPNP**

 *Pediatric Urologist Pediatric Urologist Pediatric Nurse Practitioner Pediatric Nurse Practitioner*