Patient Name: _____ DOB: _____

Pediatric Urology of Western New York PC

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.

Date: _____

Time	Urine	Volume	A	BM	S
Over-night					

Date: _____

Time	Urine	Volume	A	BM	S
Over-night					

CUPID: Center for Urology and Pediatric Incontinence Disorders

Saul P. Greenfield, MD *Pediatric Urologist*
Pierre Williot, MD *Pediatric Urologist*
Allyson Fried, CPNP *Pediatric Nurse Practitioner*
Sabrina Meyer, CPNP *Pediatric Nurse Practitioner*

Doctor/ NP Signature _____ Date: _____

Patient Name: _____ DOB: _____

Date: _____ Date: _____

Time	Urine	Volume	A	BM	S	Time	Urine	Volume	A	BM	S
Over-night						Over-night					

Anything additional that we should be aware of:

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Doctor/ NP Signature _____ Date: _____