IUPUI Health Services

URINARY TRACT INFECTION QUESTIONNAIRE

Name: ___________________________________  Today’s Date: ________________
Allergies: ___________________________________  Date of Birth: ________________
Temp: _______  B/P: _________  P: _____  Wt: __________  Height: __________

Please answer questions 1 through 8:

1. Please circle the symptoms you are experiencing. (& explain if space)
   question):
   Frequency: How many times an hour do you urinate? __________
   Dysuria: (Burning or pain on urination)
   Hematuria: (Blood in urine)
   Urgency: (sudden need to urinate)
   Nocturia: (awakening during sleep to urinate)
   How many times during your sleep? ______
   Incontinence: (loss of control)
   Back pain: if yes, right side, left side or both?________________
   Fever: if yes, highest temp _______ for how many days? ___

2. How long (days) have you had these symptoms?___________

3. Have you had a previous urinary tract infection(UTI)? Yes No
   If yes, more than 2 per year? Yes No
   Please list medication taken for past UTI:__________________________
   _______________________________________________________________

4. Have you ever had an infection of the kidney? Yes No

5. Have you taken any medication for current symptoms? Yes No
   List all prescription, over the counter medication, or herbs that you
   have taken in the last 2 days:__________________________________
   _______________________________________________________________
   _______________________________________________________________

6. Females only: when did your last menstrual cycle begin?___________

7. Do you drink caffeinated beverages? (soft drinks/coffee/tea) Yes No
   if yes, how many ounces per day? ______________________________

8. Are you sexually active? Yes No
   If yes, when did you last have sex? _______________________________

Urinalysis results: Color:_______ Turbidity:_______ pH:_____ Sp. Gr.:_______
Labstix results:________________________________________________________

Reviewed by (nurse):_______________________

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER:

Notes:________________________________________________________________

Microscopy results:_____________________________________________________
Tests ordered:  U/A   with micro  C&S   CBC  w/diff  w/o diff ________________
RX/Plan:________________________________________________________________

____________________________________
Physician/Nurse Practitioner Signature

12/14/2004
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