

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:

- 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? _____
- How long (days) have you had these symptoms? _____
- 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: _____

- Have you ever had an infection of the kidney? Yes No
- 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: _____

- Females only: when did your last menstrual cycle begin? _____
- Do you drink caffeinated beverages? (soft drinks/coffee/tea) Yes No
if yes, how many ounces per day? _____
- 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