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|  | **Name…………………………………………………..****D.O.B. …………………………………………………****Contact No. ………………………………………….** |

**Urine Sample Questionnaire**  **Time Sample Left** ………………………………. |
| **Please circle your symptoms as appropriate:**Female patients – Are you pregnant/planning a pregnancy Yes / No On your period Yes / NoPain/stinging/discomfort on passing urine Yes/ NoUrine is smelly or cloudy Yes / NoNeeding to urinate at night more than usual Yes / NoUrgency to pass urine Yes / NoIncrease in number of times passing urine per day Yes / NoNew lower abdominal pain/discomfort Yes / NoHave you noticed any blood in your urine Yes / NoFever/chills or feeling nauseous or unwell Yes / NoNew back pain/discomfort Yes / NoNew/Worsening confusion Yes/NoNew/worsening urinary incontinence Yes/NoDo you have a catheter? Yes / NoPrevious water infection in the last 3 months Yes / NoNew discharge from vagina/penis Yes / NoAny Allergies or Other comments ­…………………………………………………………………………………………....................................**A nurse will contact you with the plan of care.**Would you be happy to be contacted via text message if appropriate? Yes / NoDo you have a nominated Pharmacy where we can send a prescription if required?Please specify ……………………………………………………………PTO if need more space |