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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 / No  Pain/stinging/discomfort on passing urine Yes/ No  Urine is smelly or cloudy Yes / No  Needing to urinate at night more than usual Yes / No  Urgency to pass urine Yes / No  Increase in number of times passing urine per day Yes / No  New lower abdominal pain/discomfort Yes / No  Have you noticed any blood in your urine Yes / No  Fever/chills or feeling nauseous or unwell Yes / No  New back pain/discomfort Yes / No  New/Worsening confusion Yes/No  New/worsening urinary incontinence Yes/No  Do you have a catheter? Yes / No  Previous water infection in the last 3 months Yes / No  New discharge from vagina/penis Yes / No  Any 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 / No  Do you have a nominated Pharmacy where we can send a prescription if required?  Please specify ……………………………………………………………PTO if need more space |