Name……..

D.O.B. ……

Contact No.

…….

Urine Sample Questionnaire

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