Urine Sample Questionnaire

Name………………………………………………..

D.O.B. ………………………………………………

Contact No. ……………………………………….

Please circle your symptoms as appropriate:

Pain/Stinging/Discomfort when passing urine	Yes / No
Increase in frequency/number of times passing urine	Yes / No
Lower back pain/discomfort	Yes / No
Abdominal pain/discomfort	Yes / No
Urgency to pass urine	Yes / No
Fever or feeling unwell	Yes / No
Previous water infection in the last 3 months	Yes / No
Any odour or cloudiness to your urine	Yes / No
Have you noticed any blood in your urine	Yes / No
Have you tried over the counter treatment from the Pharmacy?	Yes / No
Any discharge from your vagina / penis?	Yes / No
Do you have a catheter?	Yes / No
Following two questions for female patients only	
Are you pregnant/planning a pregnancy ?	Yes / No
Are you on your period?	Yes / No

Any Allergies or Other comments -

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A nurse will call you later today/tomorrow with the results and plan of care.

Do you have a nominated Pharmacy where we can send a prescription if required?

Please specify ……………………………………………………………………………………………………….