Name:_____ Date of birth_____ Male /Female

# Suspected Urinary Tract Infection patient questionnaire

New Symptoms (please tick all those which apply)

| | | | |
|---|---|---|---|
| Pain on passing urine. | ☐ | Increased frequency of passing urine. | ☐ |
| Urgency when passing urine. | ☐ | Blood in the urine. | ☐ |
| Soreness down below when NOT passing urine. | ☐ | Itching. | ☐ |
| Discharge from the vagina or penis. | ☐ | Abdominal pain, if so where? . …….. | |
| Back pain. | ☐ | Temperature symptoms, (circle as appropriate) Feeling; hot / cold / sweaty | |

How many days? …….

| | | |
|---|---|---|
| 1. | When did you last move your bowels? | ……... |
| 2. | How much are you drinking daily? (number of cups per day) | ……... |
| 3. | Do you have a previous history of urinary tract infection? | Yes / No |
| 4. | Have you had an infection in the last 4 weeks? | Yes / No |
| 5. | How many infections have you had in the last 12 months? | ……... |
| 6. | How many courses of antibiotics have you had for your UTI(s)? | |
| 7. | Are you (or could you be) pregnant? If so, how many weeks pregnant? | Yes / No ……... |
| 8. | Please note any drug allergies. | ……... |
| 9. | Do you take methotrexate? | Yes / No |
| 10. | Do you have a urinary catheter? | Yes / No |
| 11. | Who changes your catheter? | ……... |

Preferred Pharmacist: _____

**Contact telephone Number:** _____

Please read Mid-Stream Urine (MSU) leaflet carefully before collecting your urine sample.

Please leave your specimen and this questionnaire at the GP reception ideally before midday. Please ensure the pot is clearly marked with your name, date of birth and the time the specimen was collected.

Ask receptionist for UTI leaflet.