Suspected Urinary Tract Infection patient questionnaire

Name:______________________________

Date of birth:__________

Date:__________

Please tick which symptoms you have:

Pain on passing urine.	☐	Passing urine more frequently	☐
Urgency when passing urine.	☐	Blood in the urine.	☐
Soreness down below when NOT passing urine.	☐	Itching.	☐
Discharge from vagina or penis.	☐	Passing urine more often than usual at night	☐
Back pain / Loin pain	☐	Cloudy urine	☐
Temperature symptoms, (circle as appropriate) Feeling hot +cold / sweaty Thermometer reading (if known):_____ºC/F		Abdominal pain, if so where?	

How many days? ....

1.	How much are you drinking daily? (number of cups per day)	....
2.	Are you (or could you be) pregnant? If so, how many weeks pregnant?	....
3.	Do you suffer from recurrent urinary infections?	....
4.	Please note any drug allergies.	

Any additional relevant information: ______________________________________

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Contact telephone Number: ______________________________

Please leave your sample with reception, make sure it is clearly labelled. The GP will review your form and test your sample and then either text you or call you.

If a prescription is issued it will be available to collect from reception after 3pm.