

RECURRENT URINARY TRACT INFECTION - FEMALES

LAST Name (REQUIRED) FIRST Name (REQUIRED) PHN/CARE CARD NUMBER (REQUIRED)

Date _____

Instructions: Please complete this questionnaire as completely as possible. All information is strictly confidential and will assist in your evaluation.

Mark [X] the correct column after each question. If YES to any of the below questions, please explain.

ONSET Age at first bladder/kidney infection? _____ How many years have recurrent infections been a MAJOR problem for you? _____				TIMING How frequently are you having infections (e.g. once per week, every few months)?			
	Yes	No	Not Sure		Yes	No	Not Sure
SYMPTOMS DURING INFECTION: Any of these WITH infection?				RISKS: Do any of the following apply to you?			
1. Burning (dysuria)				21. Post-menopausal			
2. Frequent urination				22. Oral contraceptive			
3. Urgency/difficulty postponing urination				23. Vaginal dryness			
4. Foul-smelling urine				24. Spermicidal jelly			
5. Blood in the urine				SEXUAL ACTIVITY: Intercourse is a major risk for recurrent UTI.**			
6. Upper back pain				25. Are you sexually active?			
7. Fever				26. Do you have pain with intercourse?			
8. Nausea or vomiting				27. Do you get infections after intercourse?			
9. Pain above the bladder or lower back				PRIOR INVESTIGATIONS: Have you had any of the following in the past?			
INTERCURRENT SYMPTOMS: Any of the following when you DO NOT have infection?				28. Positive urine culture			
10. Slow stream				29. Cystoscopy			
11. Difficulty emptying your bladder				30. Ultrasound			
12. Urinary incontinence/leakage				TREATMENT: Which have you received?			
13. Do you need pads for incontinence?				31. Antibiotics			
UROGYNECOLOGY HISTORY : Do any of the following apply to you?				32. Vaginal estrogen replacement			
14. Kidney stone				33. Cranberry (extract, pills, juice)			
15. Bladder surgery				34. Probiotics (e.g. Lactobacilli)			
16. Hysterectomy (removal of uterus)				35. D-Mannose			
17. Oophorectomy (removal of ovaries)				36. Vitamin C			
18. Vaginal surgery (prolapse or incontinence)				37. Urethral dilation (stretch of urethra)			
19. Constipation							
20. Neurological problem (stroke, MS, etc.)							
21. History of smoking							

Explain if you answered YES to any of the above. Is there anything else that you think is important for us to know?

**If infections are related on intercourse, roughly how frequently are you having sex per month?

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PLEASE COMPLETE ALL PAGES