Outcomes

ACUTE UNCOMPLICATED URINARY TRACT INFECTION (UTI)

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	

SCREENING QUESTIONNAIRE

	Yes	No	Don't Know
Are you currently experiencing painful urination or increased urinary urgency and/or frequency?	☐	☐	☐
For women: Are you currently pregnant?	☐	☐	☐
For women: Are you post-menopausal?	☐	☐	☐
For women: Are you currently experiencing any vaginal discharge or itching?	☐	☐	☐
Did the symptoms start more than 7 days ago?	☐	☐	☐
Are you currently experiencing fever, nausea/vomiting, or flank pain?	☐	☐	☐
Do you currently have a condition such as cancer, leukemia, or HIV/AIDS that weakens your immune system?	☐	☐	☐
Are you currently taking cortisone, prednisone, other steroids, anticancer drugs or had any radiation treatment?	☐	☐	☐
Do you have a history of Diabetes?	☐	☐	☐
Do you have a history of kidney dysfunction or transplant?	☐	☐	☐
Do you currently have an indwelling catheter or kidney stents?	☐	☐	☐
Do you have a history of kidney stones or neurogenic bladder?	☐	☐	☐
Have you had a UTI in the past?	☐	☐	☐
If you answered yes to the previous question, have you had more than three UTIs in one year?	☐	☐	☐
Have you had antibiotic medication prescribed due to a UTI in the last 30 days?	☐	☐	☐
Have you been admitted to a healthcare facility in the last 30 days?	☐	☐	☐
Do you currently smoke tobacco? I*f yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per day?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐