Full Name_____ D.O.B.___/___/_____ Date: ___/___/_____

UTI Urinary Tract Infection Visit (You may also complete this form online at www.yourhealthfile.com.)

Emmanuel Christian Health Center 918 Rolling Acres Rd., Ste 1 & 2, Lady Lake, FL 32159 (352) 259-1991
Vivian J. Woodard, M.D. Courtland L. Munroe, M.D. Board Certified Internal Medicine Physicians

1. How long has it been since your last urinary tract infection? (check one)

never had UTI before now __ 2 to 4 weeks ago__ 1 month__ 1 to 2 months__

3 to 6 months __ 6 months to a year__ 1 to 2 years__ a few years ago__ many years ago__

2. Indicate if you have any of the following symptoms: (check all that apply)

burning or pain when you urinate__ an increase in the number of times you urinate__

a stronger than usual urge to urinate __ see blood in your urine__ new or worsened back pain__

stomach pains__ have urge to urinate but not much urine comes out__

feel like you are not emptying your bladder completely__ trouble starting the flow of your urine__

urine looks cloudy__ urine smells bad__ pain in pelvis or lower part of belly__

new (or worsened) loss of bladder control__ longstanding loss of bladder control__

pain in your side__ a slow or weak urine stream__ other symptom(s)_____

3. How bad are your symptoms? mild__ moderate__ severe__ improving__ getting worse__

4. How long have you had your current urinary tract symptoms? less than 24 hours__ 1 day__

2 to 3 days__ 4 to 6 days__ 1 week__ 1 to 2 weeks__ about 2 to 3 weeks__ more than 3 weeks__

5. Do you have any of these other associated symptoms? (check all that apply)

diarrhea__ nausea__ vomiting__ sores in your privates__ a rash in your privates__ none of these__

(ladies only) discharge from vagina__ **(**men only) discharge from penis__

6. Have you had a fever with your symptoms? Yes__ No__ **If yes, how high?** _____ degrees

7. Have you tried any over-the-counter medications to treat your symptoms? Yes__ No__
If yes what is name or type of medication(s)? _____

8. Have you already been treated with an antibiotic or prescription for this UTI? Yes__ No__
If yes, list all antibiotic(s) you have recently taken: _____

9. Have you recently seen another healthcare provider for this UTI? Yes__ No__
If yes what is the specialty of that provider? urologist__ gynecologist__ urgent care__
walk-in clinic__ emergency room__ another primary care__ other type of healthcare provider__

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10. Which *best* describes the recent treatment for your urinary tract infection symptoms?

I have not yet received treatment__ I have been treated recently but the treatment did not work__

I got better with treatment but symptoms have now come back__ I am receiving treatment now but

the treatment is not helping__ I am receiving treatment now and the treatment is helping__

11. Have you had recent blood or urine tests related to your urinary tract symptoms? Yes__ No__
If yes, what is name or type of test? _____

12. If you have had urinary tract infections in the past is there a particular antibiotic that usually makes you better? Yes__ No__ N/A__ **If yes, name the antibiotic**:_____

13. Have you had any recent radiology exam(s) related to your symptoms? Yes__ No__
If yes, what is name or type of radiology test? _____

14. Have the symptoms of urinary tract infection caused you to be unable to perform your daily activities such as a job or housework? Yes__ No__

15. Men only: Have you ever had prostate gland trouble? Yes__ No__

16. Men only: Have you ever been treated for a prostate infection? Yes__ No__

Medical History *(please complete if we have not seen you as a patient in the past month)*

***Check* if you're allergic to:** No allergies___ Penicillin____ Sulfa___ Aspirin___ Codeine___ Iodine___ Latex___ Cipro___ Macrodantin___ Bactrim___ Keflex___	**List all allergies to other drugs:**
Please give us an up to date list of names and dosages of all medicines you are taking:	
***Check* if you *have now or ever had* :** ___stroke[436] ___heart attack[412] ___ COPD[496] ___blocked arteries in your heart[41401] ___diabetes[25000] ___high blood pressure[4011] ___high cholesterol[2720] ___asthma[49390] ___underactive thyroid[2449] ___ kidney stones[5929] ___chronic kidney disease[5859] ___breast cancer[1749] ___prostate cancer[185] other cancer (what kind?):	
Have you ever had any other serious medical problems? No___ Yes___ If yes, please list:	
What surgeries have you had? heart bypass___ heart valve___ tonsils out___ gallbladder out___ appendix out___ uterus out___ kidney removed___ others (list them):	
Tobacco use: never used ___ quit smoking___ when? _____ still smoke, dip or chew___ **Alcohol use:** never used ___ ex-drinker___ occasional___ social___ light___ heavy___	
Ladies only: Is there a chance you could be pregnant? No___ Yes___ Not Sure___ When was your last period?_____	