



Questionnaire Urinary Tract Infection, to be completed by the patient

Date: _____

Name: _____ M / F

Date of birth: _____ Tel: _____

The urine is being examined in connection with: <input type="checkbox"/> a new complaint / <input type="checkbox"/> finishing a course of treatment	
At what time did you collect the urine? _____ hours	
How long had it been since you last urinated when you collected this urine? _____ hours	
Are you handing in a sample of washed mid-stream urine?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Did you store the urine in the fridge?	<input type="checkbox"/> yes / <input type="checkbox"/> no
When did you start having the complaints?	
Do you recognise the complaints from previous episodes?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Do you have a burning sensation or pain while and/or after urinating?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Are you urinating more often than normal?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Are you able to pass only small amounts of urine, or do you constantly feel like you need to urinate?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Do you have urinary incontinence?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Do you have a fever of over 38°C?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Any pain in your back, side, flanks, lower abdomen? If so, where	<input type="checkbox"/> yes / <input type="checkbox"/> no
Is there blood in your urine? (NB: no menstrual blood)	<input type="checkbox"/> yes / <input type="checkbox"/> no
Do you feel ill?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Do you have discharge from your vagina or penis?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Other complaints:	
Are you pregnant? If so, how many weeks	<input type="checkbox"/> yes / <input type="checkbox"/> no
Is it possible that you have a sexually transmitted disease (STD)?	<input type="checkbox"/> yes / <input type="checkbox"/> no
Are you allergic to any antibiotics, and if so, which?	<input type="checkbox"/> yes / <input type="checkbox"/> no
If the urine comes from a child under the age of 12, what is the child's weight?	



Urine collection instructions (washed, mid-stream)

- Preferably morning urine, at least 4 hours after you last urinated.
- Use the sterile container with the red cap that the assistant provided you with to collect the urine.
- First urinate a little bit into the toilet, then catch the urine in the container and finish urinating in the toilet.



For women:

Wash the labia and the area between the labia with water, and dab yourself dry. Use 2 fingers to keep the labia apart while urinating.

For men:

Pull back the foreskin, clean the glans with water, and dry it. Pull the foreskin back while urinating.

- Carefully close the container with the cap, and write your name and date of birth on the container.
- Immediately bring the urine to the doctor's office. If this is not possible, the urine must be kept in the **fridge**.
- Please complete this form (your details and complaints).
- Hand in the urine before _____ o'clock. You can call about the results after _____ o'clock.

The below section is to be completed by the doctor's assistant

Stick	Uricult	Sediment
Nitriet: <input type="checkbox"/> pos/ <input type="checkbox"/> neg	Uricult: <input type="checkbox"/> pos/ <input type="checkbox"/> neg	Bacteriën:
Leukocyten:	Kiemgetal:	Leukocyten:
Erytrocyten:	Cled (groen):	Erytrocyten:
Ketonen:	McConkey (roze):	Amorf:
Glucose:		Epitheel:
Proteïne:		Overig: