

Name: _____

Date of Birth : _____

Telephone number : _____

The urine test is because of:

Possible bladder infection

Check after bladder infection

Possible diabetes

Pregnancy test (important: you need to pay for this at the practice)

Time urine sample was taken: _____

When did your symptoms start? _____

	No	Yes	
Pain or burning sensation during/after urinating	<input type="checkbox"/>	<input type="checkbox"/>	
Urinating often, small amounts	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in bladder region	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in your back	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____C
Do you have a catheter?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have kidney- or bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you losing urine (incontinence)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you feel unwell?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you allergic to antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	
If so, which one?:	_____		

Are you at risk for sexually transmitted infection?

(i.e did you have unprotected sex in the last weeks)? No Yes

For women:

Are you having a period? No Yes

Are you pregnant? If so, how many weeks? No Yes _____ weeks

Are you breastfeeding? No Yes

Do you have itch in the vulva/vagina? No Yes

Do you have vaginal discharge? No Yes

For men:

Do you have discharge from your penis? No Yes

For children younger than 12 years: Weight: _____ kg

Please give this form to the receptionist.

You can call between 10.00 and 12.00 a.m. for test results.

In te vullen door de assistente:

pH: _____ Leucocyten : _____ Bloed: _____
Glucose: _____ Nitriet: _____ Ketonen : _____ Eiwit: _____