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Recurrent Urinary Tract Infections Questionnaire

Name _____ Date _____

1. How long have you had problems with urinary tract infections? _____ months _____ years
2. On the average how often have the infections occurred? every _____ week _____ month _____ year
3. When was your last infection? _____
4. What was the last infection treated with? _____

5. Are you taking antibiotics at the present time? Yes No

6. Please circle the symptoms you experience during your infections:

frequent urination urgency burning during voiding
low back pain incontinence pressure over bladder

7. Have you ever had during your infections? (please circle)

blood in urine high fevers upper back/flank pain air or stool passed with the urine

8. Have you ever required hospitalization for a urinary tract infection? Yes No

If yes, where and when _____

9. Do your infections frequently follow sexual intercourse? ___ rarely ___ occasionally ___ often

10. Do you often have pain with intercourse? ___ rarely ___ occasionally ___ often

11. Do you have a history of diabetes? Yes No

kidney or bladder stones Yes No
diverticulitis or Crohn's disease Yes No
stroke, multiple sclerosis or other Yes No
neurological disease Yes No

12. Do you have difficulty emptying your bladder? Yes No Have you been tested to determine whether urine is left behind in the bladder after you void? Yes No

Results of test if done _____

13. Do you have a slow stream or have to strain to urinate Yes No

14. Have you had previous testing for your infections? Yes No If yes, what tests? please circle:

kidney or bladder x-ray cystoscopy other tests

Were any abnormalities found? If so please specify what. _____

15. Have you ever been treated with a small amount of an antibiotic for a long time? Yes No

What antibiotic and when _____