Voiding Questionnaire

Today's Date __________________________ Date of Birth __________________________

Patient’s Name __________________________

Please complete the following questionnaire to the best of your ability, by marking the appropriate corresponding box. Bring this form with you to your appointment:

1. How many times does the patient void per day?
   - [] 0 - 2
   - [] 3 - 4
   - [] 5 - 6
   - [] 7 - 8
   - [] More Than 8

2. How often is this associated with urgency?
   - [] Never
   - [] Occasionally
   - [] Frequently

3. Do you see posturing such as squatting, holding oneself, crossing legs, or the “pee-pee” dance to avoid wetting?
   - [] Never
   - [] Occasionally
   - [] Frequently

4. Does it hurt to void?
   - [] Never
   - [] Occasionally
   - [] Frequently

5. How often is the patient wet during the day?
   - [] Never
   - [] 1 - 2 times per MONTH
   - [] 2 - 3 times per WEEK
   - [] Daily
   - [] Unsure

6. When the patient is wet, how would you describe it?
   - [] Hardly Wet
   - [] Damp
   - [] Soaked

7. How often is the patient wet at night?
   - [] Never
   - [] 1 - 2 times per MONTH
   - [] 2 - 3 times per WEEK
   - [] Daily
   - [] Unsure

8. How often does the patient wake at night to urinate?
   - [] Never
   - [] Occasionally
   - [] Frequently

9. How many urinary tract infections (UTI's) has the patient had during the past year?
   - [] None
   - [] 1 - 3
   - [] 4 - 6
   - [] More Than 6

10. When the patient’s urine was collected to be tested, how was it obtained?
    - [] Bag
    - [] Voided
    - [] Clean Catch, Mid-Stream
    - [] Catheterization

PLEASE COMPLETE BOTH PAGES OF THIS FORM
11. When symptoms were associated with the UTI’s?

Please MARK ALL THAT APPLY:

☐ Fever
☐ Flank Pain
☐ Vomiting
☐ Pain & Urinating
☐ Foul Odor

12. How often does the patient have a bowel movement?

☐ More than 1 time per DAY
☐ 1 time per DAY
☐ Every other DAY
☐ Every 2 - 3 DAYS
☐ 1 time per WEEK

13. How often is the stool hard or difficult to pass?

☐ Never
☐ Occasionally
☐ Frequently

14. How often is the patient incontinent of stool?

☐ Never
☐ Occasionally
☐ Frequently

15. Which of the following does the patient routinely eat or drink?

Please MARK ALL THAT APPLY.

☐ Soft Drinks
☐ Chocolate
☐ Lemonade
☐ Coffee
☐ Orange Juice

Patient Notes (To be completed by the physician or nurse practitioner)

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________________________________________________________________________
________________________________________________________________________
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Physician’s / Nurse Practitioner’s Signature