PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

URINARY SYMPTOMS – FEMALE

CHIEF COMPLAINT:_____

_____

_____

DURATION OF VOIDING SYMPTOMS: _____

DYSURIA:	YES _____ NO _____	**HEMATURIA:**	YES _____ NO _____
NOCTURIA:	YES _____ NO _____	**DAYTIME VOIDS:**	YES _____ NO _____
URGENCY:	YES _____ NO _____	**INCOMPLETE EMPTYING:**	YES _____ NO _____
INCONTINENCE:	_____ STRESS _____ URGE -	**NUMBER OF PADS** _____	
BLADDER PAIN:	YES _____ NO _____	**DYSPAREUNIA:**	YES _____ NO _____

PRIOR TREATMENT: _____

HISTORY OF UTI: _____

HISTORY OF UROLITHIASIS: _____

HX OF GYN PROBLEMS/SURGERY: _____

HX OF BOWEL PROBLEMS/SURGERY: _____

HX OF BACK PROBLEMS/SURGERY: _____

Provider Signature: _____ Date: _____ Time: _____

_____ Patient verbalizes understanding of instructions given

Patient Name:

Date of Birth: