



Bladder Questionnaire

HomeopathicVibes

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(Please note that this questionnaire is for therapeutic purposes only and will be confidential in all respects.)

Name (First) _____ Name (Last) _____ Age _____

Marital status (Please mark one)

Married _____ Single _____ Widow _____ Divorced _____ Separated _____

Street

Address _____ City _____ State _____ Zip _____

Home

Phone _____ work _____ cell _____

Email _____ @ _____

1. Do you feel any kind of pain? Before Urination after Urination after Urination.
2. Do you feel any kind of burning? Before Urination after Urination after Urination
3. Do you notice any blood in urine? Yes No
4. Do you notice any pus in urine? Yes No
5. Do you notice any abnormal discharge urine? Yes No
6. Do you notice any kind of swelling around vulva? Yes No
7. Do you experience any kind of Itching around vulva? Yes No
8. Any of the complaints increase after intercourse? Yes No
9. Mostly my infections happen? Before menstruation after menstruation Do not apply.
10. How often you have infections in past 6 months? Only once 2-3 times more than 3 times.
11. How do you treat them usually? Drink fluids take antibiotics others

12. What was your usual duration of infection without any treatment?

- 1-3 days
- 3-7 days.
- More than 7 days.
- Specify_____

13. What was your usual duration of infection with any treatment?

- 1-3 days
- 3-7 days.
- More than 7 days.
- Specify_____.

14. Are you using any contraceptive devices? Yes No
If yes, since how long? _____

15. Are you using any lubricating jelly? Yes No
If yes, since which one? specify _____

16. Does your husband use condoms? Yes No
If yes, which one? Latex____ rubber_____

17. Are you a Vegetarian Non Vegetarian?

18. Which types of food do you like? Spicy Mild

19. Do you have any Gastric Problem? Yes No

20. Do you have constipation? Yes No

21. Are you suffering from blood pressure
If so, whether it is? High Low

22. Do you suffer from heart problem Yes No

22. Do you sleep well Yes No

23. How many times you wake up to urinate during night?

- I don't wake up.
- 1-3 times.
- 4-6 times.
- More than 6 times.

24. Do you exercise daily Yes No

25. Your partner has any sexual problem? Yes No

26. Have you ever been treated in past? Yes No
 Homeopathic Allopathic Ayurveda others

If so details_____

27. Have you ever had kidney infection? Yes No

28. Have you ever had kidney pain? Yes No

29. What are your expectations from our treatment?

- I don't expect good results.
- I expect good results.
- I would be happy if I improve.
- I am confident.

30. Are you willing to make changes to your life style or diet modifications?

- I can not change my lifestyle.
- I have tried nothing works for me,
- I am willing to change my lifestyle if needed.
- I am willing to do what ever is needed to get best results,