UTI QUESTIONNAIRE (women)

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(Please not 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
Adress_____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. All the complaints increase after intercourse? ○ Yes ○ No
9. Mostly my UTI happen? ○ Before menstruation ○ after menstruation ○ Do not apply.
10. How often you have UTI s 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 ○ Yes ○ No

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,