OSCEOLA UROLOGY ASSOCIATES

An Affiliate of Osceola Regional Medical Center

FEMALE UROLOGICAL WORK-UP

Today's Date: _____

Name: _____ Age: _____ Family or Referring Doctor: _____

DO YOU HAVE TO:

Push to get the water started (urinate)? _____ Yes No

Urinate more frequently than normal? _____ Yes No

Get up at night to urinate? _____ Yes No

If yes, circle number of times: 1 2 3 4 5 6 7 or more

Go immediately when you get the urge? _____ Yes No

During the day, how often do you urinate? 1 2 3 4 5 6 7 or more

HAVE YOU HAD, OR DO YOU HAVE:

Take longer to empty the bladder than normal? _____ Yes No

A decrease in the size of your stream? _____ Yes No

A feeling of not emptying your bladder? _____ Yes No

Trouble starting the stream? _____ Yes No

Pain or burning with urination _____ Yes No

If yes, during or after (circle one)

Pain? Back Abdomen Pelvis Above Pubis

Blood in urine? _____ Yes No

If yes, was it throughout the stream? _____ Yes No

At the beginning only? _____ at the end only? _____

Loss of urine when you strain? _____ Yes No
Such as lifting, coughing, sneezing, etc.

Loss of urine if you don't get to the bathroom on time? _____ Yes No

Loss of urine at other times? _____ Yes No

A vaginal infection or discharge? _____ Yes No

Any other urological problems? _____ Yes No

Have you ever seen a Urologist or Kidney specialist before? _____ Yes No

If so Whom? _____ When? _____

Have you ever had an IVP? (Kidney X-Rays) _____ Yes No

Have you ever had urinary surgery? _____ Yes No

 If so, When? _____ For What? _____