

My UTI History

This handout is intended to provide you with a template to communicate clearly and effectively with your clinician. The goal is to help you streamline your medical history so it can be shared in a clear and concise manner. We recommend completing this in advance of any upcoming medical appointment and referring to it as needed when consulting with your clinician.

Note: Clinicians prefer 'pain scales' when understanding patient symptoms. This typically means ranking your symptoms on a scale of 1-10, with 10 being the most severe.

In addition to completing the pain scales on this form, you may record your symptoms over time using the scale to better track healing progress.

LIVE
UTI FREE



CLEMENTINE
NATURAL HEALTH

GOALS OF TREATMENT

Be prepared to relay to your clinician what you hope to achieve by pursuing treatment with them.

My goals for treatment are:

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SYMPTOMS

Past Symptoms

At what age did you **first** develop urinary tract symptoms?

What were the **top three** symptoms that you were most affected by when your **symptoms first began**?

1.
2.
3.

Have your symptoms changed since their initial onset? YES / NO

Current Symptoms

Do you ever have periods of time without symptoms? YES / NO

How long do these symptom-free times last?

What are the **top three** symptoms that you have been most affected by during your **most recent episode**?

1.
2.
3.

At what age did the **current episode** of symptoms begin?

Describe any circumstances that contribute to the development of your symptoms (e.g. stress, sexual activity, new medication, medical procedure, change in diet, change in personal care, etc.):

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URINE TESTS

Please complete the chart below as it relates to urine tests from the **past two years**.

Note: Some clinicians may request to view previous reports, while others may prefer to perform their own analysis. It can be helpful to have reports from the past two years ready to present, if requested.

Test	Date completed	Results
Urine Dipstick (tested same day in clinic)		
Urine Culture & Sensitivity (sent off to a lab)		
Advanced DNA Testing (E.g. Cirrus, MicroGenDx, Pathnostics)		

DIAGNOSTIC IMAGING

Imaging	Date completed	Results
Cystoscopy		
Pelvic Ultrasound		
MRI		
Other		

CURRENT MEDICAL HISTORY

Allergies to medications:

Other health conditions (e.g. hypothyroidism, endometriosis, perimenopause, fertility concerns, etc.):

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Current medication or supplement	Dose	Date began	Purpose of product

PAST MEDICAL HISTORY

Past surgeries, medical procedures, and/or medications	Response to treatment (e.g. symptom response, change in lab results, etc)

FAMILY HISTORY

Any family history of bladder related concerns (e.g. bladder, prostate or gynecological cancers, interstitial cystitis, prostatitis, etc.)?

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Describe anything else not listed on this form that you think is important for your clinician to know.

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