SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
RETROGRADE URETHROGRAM

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____

Height _____ Weight _____ Patient# (Internal use only) _____

REASON FOR EXAM *(Please include symptoms and time frame):*

TECH NOTES *(for internal use only)*:

Previous Cystoscopy or RUG findings:

Additional Tech Notes:

Previous Imaging Studies Related to Todays Exam	Date

Previous Surgeries Related to Todays Exam	Date

Have you ever had any of the following procedures in the past (if yes, please indicate when):

Urethral dilation ☐ **Yes** ☐ **No** _____ **Bladder surgery** ☐ **Yes** ☐ **No** _____

Urethral surgery ☐ **Yes** ☐ **No** _____ **Prostate surgery** ☐ **Yes** ☐ **No** _____

Are you currently or have you ever experienced any of the following *(If it is no longer occuring, please tell us* ***when*** *it happened (****example:*** *August, 2020). If it is still happening, please tell us* ***how long*** *(****Example:*** *2 months)***:**

Recurrent UTI ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Urethral Stricture ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Incomplete Voiding of Urine ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Hematuria (blood in urine) ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Bladder/Urethra Diverticulum ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Congenital Urinary Anomalies ☐ **Yes** ☐ **No** **If yes, please explain:** _____

Bladder/Urethral Injury ☐ **Yes** ☐ **No** **If yes, when did injury occur?** _____

Trauma to Pelvis ☐ **Yes** ☐ **No** **If yes, when did trauma occur?** _____

Bladder Outlet Obstruction ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Difficulty Voiding Urine ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Urethral Obstruction ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Bladder/Urethral Fistulas ☐ **Yes** ☐ **No** **If yes, when or how long?** _____

Cancer ☐ **Yes** ☐ **No** **If yes, please explain:** _____

Other important medical conditions: _____

_____

Current Medications:

I agree that the above information is correct *(Do not fill out until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____