SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
VOIDING CYSTOURETHROGRAM/CYSTOGRAM

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 VCUG or Cystoscopy 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):

Deflux procedure ☐ Yes ☐ No _____ **Ureteral reimplantation** ☐ Yes ☐ No _____

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

Prostate surgery ☐ Yes ☐ No _____ **Kidney 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)*:

Urinary Tract Infection (UTI) associated with Fever ☐ Yes ☐ No **If yes, when or how long?** _____

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

Hydronephrosis (fluid in Kidneys) ☐ Yes ☐ No **If yes, when or how long?** _____

Urinary Incontinence ☐ Yes ☐ No **If yes, when or how long?** _____

Vesicoureteral Reflux ☐ Yes ☐ No **If yes, when or how long?** _____

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

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

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

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 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: _____