

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)

Date: _____

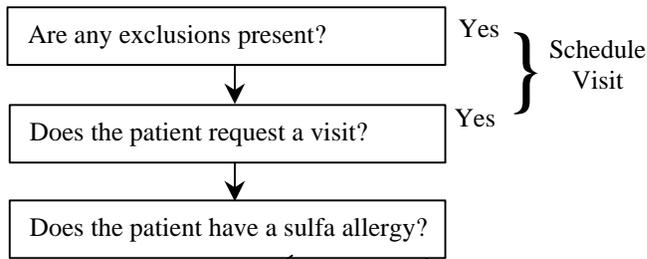
Time: _____

Acute Uncomplicated Dysuria or Urgency in Women

Chief Complaint: _____

Current Medications: _____

Medication Allergies: _____



Medication(s):

1. Trimeth/Sulfa DS
 1 BID x 3d (6 doses)

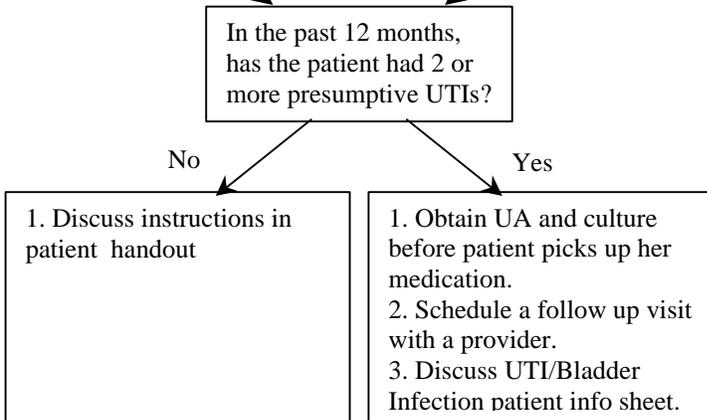
May add for discomfort:
 Pyridium 200 mg
 TID x 2d

Medication(s):

Top Choice:
 Trimethoprim alone
 200 mg BID x 3d

Next Choice:
 Nitrofurantoin
 100 mg QID x 3d

May add for discomfort:
 Pyridium 200 mg
 TID x 2d



EXCLUSIONS		Yes	No
1. Fever, documented (> 100.5° F or 38°C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nausea, vomiting, abdominal pain (Slight tenderness over bladder area is not an exclusion.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Known pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Immunocompromised (receiving immunosuppressive medication or has condition)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Symptoms > 7 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Symptoms of vaginitis (vaginal discharge, vaginal irritation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Recent or persistent urinary stone disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chronic renal or urologic abnormalities other than stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Gross hematuria in women > 50 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Within the last 2 weeks has the patient:			
11. Been treated for UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Had a catheterization or other urologic procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Been discharged from the hospital or nursing home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____ Date _____
 MD, PA or ARNP

Signature: _____ Date _____
 RN

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)

RECORDS MAINTAINED AT:		
PATIENT'S NAME (Last, First, Middle initial)		SEX
RELATIONSHIP TO SPONSOR:	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

HP: _____ WP: _____