BLADDER SYMPTOM DIARY

Track your symptoms in the diary below according to your doctor's recommendations. If you had no episodes on a given day, record that as well. Please record your urgency rating even if you did not experience leakage. Only those receiving therapy indicated for retention need to complete the retention columns. Talk with your doctor if you have questions about completing this diary.

Appt Date:				
Appt Time				

Please arrive 15 minutes early for appointment

UCA Women's Center 3125 Independence Dr. Suite 200 Homewood, AL 35209

PATIEN	MAN TV	E:								
DATE	OF BIRT	H:				EVALUATIO	ON: STARTED ON	_//	AT:_	TIME
						C	DAB		RETEN	NTION
Date	Time	Fluid Intake: Amount/Type	Asleep?*	Void Yes/No	Voided Volume (mL or OZ)	Urgency: 0-4 (4 is HIGH)	Leak: 1-3 1Slight/2Moderate/3Heavy	Change Pad/ Protective Underwear? Yes/No	Voided Volume (mL or OZ)	Cathed Volume (mL or OZ)



^{*}Were you asleep or trying to sleep when the symptom occured?

		OAB						RETENTION		
Date	Time	Fluid Intake: Amount/Type	Asleep?* ✔	Void Yes/No	Voided Volume (mL or OZ)	Urgency: 0-4 (4 is HIGH)	Leak: 1-3 1Slight/2Moderate/3Heavy	Change Pad/ Protective Underwear? Yes/No	Voided Volume (mL or OZ)	Cathed Volume (mL or OZ)

Do you feel that this therapy is providing you relief? (circle one) yes no

How would you characterize your improvement? (circle one)

slightly improved moderately improved greatly improved

*Were you asleep or trying to sleep when the symptom occured?

Please visit **medtronic.com/bladder** for helpful information

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