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 symptom tracker.

PATIENT NAME _____ MY EVALUATION STARTED ON ____/____/____

DATE OF BIRTH _____ AT ____:____ TIME

		OAB				Retention			
Date	Time	Void ✓	Leak ✓	Pad: Mild, Moderate, Soaked	Urgency? Rate 1–5 (5 is high)	Void ✓	Voided Volume	Cath Y or N	Cathed Volume (or PVR)

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* *markedly improved*

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Further, Together

		OAB				Retention			
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PATIENT NAME _____

DATE OF BIRTH _____

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