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.

PATIENT NAME: _____ ☐ BASELINE ☐ POST-IMPLANT

DATE OF BIRTH: _____ ☐ EVALUATION: STARTED ON ____/____/____ AT _____:_____TIME

				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)

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

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				OAB					RETENTION	
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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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