

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

		OVERACTIVE BLADDER (OAB)			RETENTION		
Date	Time	Urgency: 0-4 (4 is high)	Leak: 1-3 1. Slight 2. Moderate 3. Heavy	Did you change your protective pad/ underwear? Yes/No	Void Yes/No	Voided volume (mL or oz.)	Cathed volume (mL or oz.)
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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

Please visit medtronic.com/bladder for helpful information.