

## VOIDING DIARY RECORD

Please record all voiding events and answer all questions as they relate to each event. The summary page asks you questions as they relate to all your events at the end of **each day**. Please keep this voiding diary for 4 consecutive days (for example, Monday through Thursday).

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Physician: \_\_\_\_\_

Hospital: \_\_\_\_\_

Date Diary Begins: \_\_\_\_\_

Date Diary Ends: \_\_\_\_\_

Do you have a stimulator?                      YES                      NO

Do you use it?                                      YES                      NO

Continence Control Therapy: Patients should always discuss the potential risks and benefits of Interstim® Continence Control Therapy with a physician.

CAUTION: U.S. Federal law restricts this device to sale, distribution, and use by or on the order of a physician.

# SUMMARY PAGE

	Day 1	Day 2	Day 3	Day 4
1. Please rate your force of urine stream on average for each day.	Strong	Strong	Strong	Strong
	Good	Good	Good	Good
	Fair	Fair	Fair	Fair
	Poor	Poor	Poor	Poor
2. Please rate pelvic/bladder discomfort you experienced <i>each day</i> .	None	None	None	None
	Mild	Mild	Mild	Mild
	Moderate	Moderate	Moderate	Moderate
	Severe	Severe	Severe	Severe
3. On average, how many bowel movements do you have per <b>week</b> ? _____ per <b>week</b>				
If you have a stimulator, please complete question #4.				
4. Has your bowel function changed since baseline? _____ YES* _____ NO				
*If YES, has your bowel function: _____ improved _____ worsened				

Please record date and time and answer *every* question *each* time you go to the toilet and/or have a leaking episode.

Date:		
Time:	a.m.	a.m.
	p.m.	p.m.
1. Volume voided into <i>measuring</i> cup.	ml	ml
2. Volume measured by catheter.	ml	ml
3. Please rate any leaking episode you experienced.  <b>Slight = a few drops</b> <b>Moderate = 1-2 Tablespoons (15-30 ml)</b> <b>Heavy = soaks pad/diaper or outer clothing</b>	None	None
	Slight	Slight
	Moderate	Moderate
	Heavy	Heavy
4. Did leaking cause you to replace your pad/diaper?	No	No
	Yes	Yes
5. Did you feel empty after voiding?	No	No
	Yes	Yes
6. Degree of urgency prior to voiding?	None	None
	Mild	Mild
	Moderate	Moderate
	Severe	Severe

a.m.	a.m.	a.m.	a.m.
p.m.	p.m.	p.m.	p.m.
ml	ml	ml	ml
ml	ml	ml	ml
None	None	None	None
Slight	Slight	Slight	Slight
Moderate	Moderate	Moderate	Moderate
Heavy	Heavy	Heavy	Heavy
No	No	No	No
Yes	Yes	Yes	Yes
No	No	No	No
Yes	Yes	Yes	Yes
None	None	None	None
Mild	Mild	Mild	Mild
Moderate	Moderate	Moderate	Moderate
Severe	Severe	Severe	Severe