






















Your Daily Bladder Diary



















This diary will help you and your health care team. Bladder diaries help show the causes of bladder control trouble. The "sample" line (below) will show you how to use the diary.

Your name: _____

Date: _____

			ACCIDENTS					
								
Time	Drinks	Urine	Accidental leaks			Did you feel a strong urge to go?		What were you doing at the time?
	What kind? How much?	How many times? How much? (circle one)	How much? (circle one)			Circle one		Sneezing, exercising, having sex, lifting, etc.
Sample	Coffee 2 cups	✓ <input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	 sm	<input checked="" type="radio"/> med	<input type="radio"/> lg	Yes	<input checked="" type="radio"/> No	Running
6-7 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
7-8 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
8-9 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
9-10 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
10-11 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
11-12 noon		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
12-1 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
1-2 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
2-3 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
3-4 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
4-5 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
5-6 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	
6-7 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/>	Yes	No	

ACCIDENTS

							
Time 	Drinks What kind? How much?	Urine How many times? How much? (circle one)	Accidental leaks (circle one)			Did you feel a strong urge to go? Circle one	What were you doing at the time? <i>Sneezing, exercising, having sex, lifting, etc.</i>
Sample	Soda 2 cans	✓ <input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes	<input checked="" type="radio"/> No	Laughing	
7-8 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
8-9 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
9-10 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
10-11 p.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
11-12 midnight		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
12-1 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
1-2 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
2-3 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
3-4 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
4-5 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		
5-6 a.m.		<input type="radio"/> <input type="radio"/> <input type="radio"/>	 <input type="radio"/> <input type="radio"/>	Yes	No		

I used _____ pads. I used _____ diapers today (write number).

Questions to ask my health care team: _____