

BLADDER SYMPTOM TRACKER

Track your symptoms in the chart 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.

DAY _____		OAB			Retention*	
Time	Void ✓	Leak ✓	Change Pad Y or N	Urgency? Rate 1-5 (5 is high)	Voided Volume	Catheter Volume (or PVR)
8:15 AM	✓	✓	Y	5		
AM						
PM						
AM						
PM						
AM						
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TOTALS						
Since starting treatment, how do you perceive your symptoms when compared to your symptoms before the therapy? <i>Much worse than expected</i> <i>Same as expected</i> <i>Much better than expected</i>						
1	2	3	4	5	6	7

*Complete these columns only if you are diagnosed with, and receiving treatment for, urinary retention.

DAY _____		OAB			Retention*	
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