

KANSAS CITY WOMEN'S CLINIC
 KCWC: A tradition of excellence since 1953

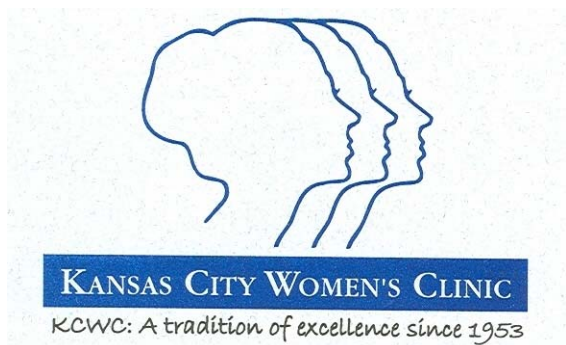
BLADDER DIARY

PATIENT: -----**SAMPLE**----- **DATE:** _____
REFERRING DOCTOR: _____ **KCWC #:** _____

TIME	FLUIDS	VOIDED AMT	SMALL ACCIDENT	LARGE ACCIDENT	REASON FOR ACCIDENT
6:35 AM		300 ML	X		URGE-LEAKED ON WAY TO BATHROOM
7:00 AM	4 OZ OJ				
	8 OZ TEA				
7:35 AM		120 ML			
9:30 AM	8 OZ TEA				
12:02 PM			X		NO URGE-SNEEZED
12:30 PM	8 OZ WATER				
1:00 PM		150 ML			
4:00 PM	16 OZ 7-UP				
5:12 PM		200 ML		X	URGE-LEAKED ON WAY TO BATHROOM
7:15 PM	8 OZ TEA				
9:36 PM		120 ML	X		URGE-COUGHED
10:50 PM	4 OZ WATER	150 ML			

INSTRUCTIONS:

- In the 1st column, record the time each time you void or drink.
- In the 2nd column, record the type and amount of fluid you drink.
- In the 3rd column, record the amount you void every time you void.
- In the 4th or 5th column, record every time you accidentally leak urine.
- In the 6th column, enter the activity you were doing at the time of the accident or the circumstances of the accident.



NAME _____

A/C # _____

DATE _____

URINARY EVALUATION

- | | | |
|---|------------------------------|-----------------------------|
| Do you have problems with accidental loss of urine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| How many months or years have you had leakage? | _____ MONTHS | _____ YEARS |
| Do you have to wear pads or protective clothing to prevent or help with urinary loss? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| If so, how many pads do you wear per day? | _____ | |
| How many trips do you make to the bathroom during the day? At night? | _____ DAY | _____ NIGHT |
| Do you ever wet the bed while sleeping? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you bothered by a strong sense of urgency to void? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Can you overcome it? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you sometimes fail to reach the bathroom in time? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does the sound, sight or feel of running water cause you to lose urine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you lose urine when you cough, sneeze, run, or lift heavy objects? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you lose urine with posture changes, standing or walking? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you feel as though you are constantly wet? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you feel as though your bladder is completely empty after passing urine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have difficulty starting a stream of urine? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |