central ohio UROLOGY group

Patient Name _____

Date of Birth _____ Start Date _____

Voiding Diary Instructions

Use one voiding diary sheet for each 24-hour period, beginning with the time that you get up for the day.

NOTE: If you are filling out this form for the sacral nerve stimulator trial period, start with the first urination after turning on device following procedure.

Overactive Bladder (OAB) Columns

Fluid Intake: Write the total amount of fluids you drank (in ounces) between toilet trips.

Caffeine: If you drank fluids, mark "Yes" or "No" indicating if beverage was caffeinated.

Void: Check box if you urinated in the toilet.

Leak: Check box if you leaked at all before getting to the bathroom.

Pad: This column describes the severity of your leak episode.

- Mild = a few drops
- Moderate = more than a few drops but not a flood
- Soaked = completely, or almost completely, emptied bladder during leak

Urgency: This rating indicates the severity of your urge on a scale from 0-4.

None	Mild	Moderate	Strong	Desperate
0	**1**	**2**	**3**	**4**

Retention Columns

This section is only for patients who are being evaluated and/or treated for urinary retention.

Void: Check box if you were able to urinate on your own.

Voided Volume: Write amount (in ounces) that you were able to void.

Cath: Mark "Yes" or "No" if you catheterized yourself.

Catheter Volume: Write amount (in ounces) from your catheter. This amount is called your post-void residual (PVR).

Please talk with your physician or the OAB Patient Navigator if you have any questions about completing this symptom tracker.

Overactive Bladder (OAB) Day: _____							Retention			
Time	Fluid Intake (oz)	Caffeine? Yes/No	Void ✓	Leak ✓	Pad: Mild, Moderate, Soaked	Urgency: Rate 0-4 (4 is high)	Void ✓	Voided Volume	Cath? Yes/No	Cathed Volume (PVR)

How much has your condition improved? ☐ None ☐ A little ☐ Moderately ☐ A lot

Overactive Bladder (OAB) Day: _____							Retention			
Time	Fluid Intake (oz)	Caffeine? Yes/No	Void ✓	Leak ✓	Pad: Mild, Moderate, Soaked	Urgency: Rate 0-4 (4 is high)	Void ✓	Voided Volume	Cath? Yes/No	Cathed Volume (PVR)

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Overactive Bladder (OAB) Day: _____							Retention			
Time	Fluid Intake (oz)	Caffeine? Yes/No	Void ✓	Leak ✓	Pad: Mild, Moderate, Soaked	Urgency: Rate 0-4 (4 is high)	Void ✓	Voided Volume	Cath? Yes/No	Cathed Volume (PVR)

How much has your condition improved? ☐ None ☐ A little ☐ Moderately ☐ A lot