

BLADDER CONTROL DIARY



I take these prescription medicines:			
Medicines	Dosage	Time of Day I Take Them	
I take these over-the-counter drugs : (vitamins & minerals, herbs (ex. Echinacea, St. John's Wort , etc.) allergy relief, antacids, aspirins, cold and cough medicines, weight management, stimulants or body boosters, etc.)			
My History: Check the best answer:			
1. I started having bladder trouble <input type="checkbox"/> recently <input type="checkbox"/> 1 to 2 years ago <input type="checkbox"/> more than 2 years ago			
2. I have had ____ children (the number) The year(s) of their birth			
3. My periods stopped (menopause) <input type="checkbox"/> in my thirties <input type="checkbox"/> in my forties <input type="checkbox"/> in my fifties			
4. I have had the following operations. (LIST ALL) <input type="checkbox"/> Not applicable			
Date	Type of Operation	Date	Type of Operation
5. I recently hurt myself or have been sick. <input type="checkbox"/> Not applicable			
Date	Type of Injury or Illness	Date	Type of Injury or Illness

	YES	NO												
6. I recently had a bladder (urinary tract) infection. If yes, date _____														
7. I am often constipated.														
8. I have pain or burning feelings when going to the toilet.														
9. I often have a really strong urge to go to the toilet right away.														
10. Sometimes my bladder feels full, even after I go to the toilet.														
11. I go to the toilet often, but very little urine comes out.														
12. I don't go out with friends or family because I worry about leaking urine.														
13. The first thing I do at new places is check the bathroom location.														
14. I worry about being put in a nursing home because of bladder control problems.														
15. I smoke cigarettes.														
16. I have (or had) these medical problems: check all that apply. <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> cancer</td> <td><input type="checkbox"/> constipation</td> <td><input type="checkbox"/> crippling arthritis</td> <td><input type="checkbox"/> depression</td> </tr> <tr> <td><input type="checkbox"/> diabetes</td> <td><input type="checkbox"/> diverticulitis</td> <td><input type="checkbox"/> interstitial cystitis</td> <td><input type="checkbox"/> multiple sclerosis</td> </tr> <tr> <td><input type="checkbox"/> spinal cord injury</td> <td><input type="checkbox"/> stroke</td> <td><input type="checkbox"/> urinary infection</td> <td></td> </tr> </table>			<input type="checkbox"/> cancer	<input type="checkbox"/> constipation	<input type="checkbox"/> crippling arthritis	<input type="checkbox"/> depression	<input type="checkbox"/> diabetes	<input type="checkbox"/> diverticulitis	<input type="checkbox"/> interstitial cystitis	<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> spinal cord injury	<input type="checkbox"/> stroke	<input type="checkbox"/> urinary infection	
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What questions could you ask?

These questions can help your health care team find the cause of your bladder control problem.

1. Could my usual food or drinks cause bladder problems?
2. Could my medicines (prescription or over-the-counter drugs) cause bladder problems?
3. Could other medical conditions cause loss of bladder control?
4. What are the treatments to regain bladder control? Which one is best for me?
5. Can you help me, or can you tell me whom I should see instead?
6. What can I do about the odor and rash caused by urine? (if this applies to you)

— Resource: http://kidney.niddk.nih.gov/kudiseases/pubs/talk_ez/index.htm
 Modified by SAFE Aging, Inc.