

TAKE CHARGE!
 Make your own copies of this worksheet and fill it out regularly. You'll soon begin to see how lifestyle changes and treatments are helping to solve your bladder problems.

Date: _____

Diet Details

Irritating foods I eliminated:

- Caffeine
- Alcohol
- Acidic fruit/juice
- Carbonated beverages
- Spicy foods
- Artificial sweetener
- _____
- _____

The changes I noticed: _____

Fiber-rich foods I added:

- Raspberries
- Blueberries
- Apples (skin on)
- Pears (skin on)
- Kidney beans
- Lentils
- Bran cereal
- _____

The changes I noticed: _____

Kegels Log

My routine:

- I exercised my pelvic muscles _____ times each day.
- I spent _____ minutes doing Kegels each day.
- During each exercise session, I squeezed my muscles _____ times.

The changes I noticed: _____

Medication List

I'm taking the following medication(s) to help with my symptoms:

Medication _____ My dose _____
 Medication _____ My dose _____

The changes I noticed: _____

Date: _____

Bladder Diary

Log your habits & improvements here.

Time of day	Food & Drink What kind? How much?	Bathroom Visits	Accidental Leaks	Did I have a strong feeling of urgency?	What I was doing at the time
7-8 a.m.	2 cups of coffee	2	1	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Sneezing
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	
				<input type="checkbox"/> yes <input type="checkbox"/> no	

Overnight Notes:

Number of trips to the bathroom: _____
 Number of overnight accidents: _____

The changes I noticed: _____

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