

Symptom Tracker

Patient Name _____

Date _____ **PRE** or **POST**



DAY	Time	Did You Void or Leak?	Was the Amount...	How Badly Did You Need to Go?	Comment
DAY	6 am		<i>Slight, Moderate, Heavy</i>	<i>Slight, Moderate, Severe</i>	
	7				
	8				
	9				
	10				
	11				
	12 pm				
	1				
	2				
	3				
	4				
	5				
NIGHT	6				
	7				
	8				
	9				
	10				
	11				
	12 am				
	1				
	2				
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NIGHT	6				
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	9				
	10				
	11				
	12 am				
	1				
	2				
	3				
	4				
	5				

How many times did you change pads today? _____ Did you change your clothes due to leaking? **YES** or **NO**

Were there any social events you chose not to attend today?

How bothersome were your symptoms today? **A little** **Somewhat** **A lot**

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