

PROBLEM: Frequency Urgency Urge Incontinence Urinary Retention

Date _____

STATUS: Before Test Stim Left Test Lead Right Test Lead Permanent Implant

Name _____

Time of Day	How much did you urinate?	How strong was the urge to urinate?	Did your urge turn into a leak?	Did you have to replace your ... (please record: clothes tissue pad Depends/diapers)	(optional) Amount of urine using a catheter? (record amount)
PLEASE RECORD EITHER SMALL, MEDIUM, OR LARGE --- PLEASE DO NOT USE HASH MARKS					
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
Noon					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
Midnight					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					
7 AM					

Please Circle Bedtime / Wakeup