Week beginning: _____ Last treatment: _____

		Fluid Intake		Urinations			Accidents			
		What did you drink?	How many cups?	How often did you go?	How much, on average?	Times you rushed to the bathroom?	How many accidents?	Pads changed?	Clothes changed?	Activity interrupted?
Day 1	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	
Day 2	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	
Day 3	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	
Day 4	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	
Day 5	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	
Day 6	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	
Day 7	Day		Total	Total	S M L	Total	Total	Total	Total	
	Night		Total	Total	S M L	Total	Total	Total	Total	

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