Week beginning: _____ Last treatment: _____

		Fluid Intake		Urinations			Accidents			
		What did you drink?	How many cups?	How often did you go?	For each time you go, circle the amount.	Times you rushed to the bathroom?	How many accidents?	Pads changed?	Clothes changed?	Activity interrupted?
Day 1	6 a.m. - 10 a.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	10 a.m. - 2 p.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	2 p.m. - 6 p.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	6 p.m. - 10 p.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	10 p.m. - 6 a.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
Day 2	6 a.m. - 10 a.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	10 a.m. - 2 p.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	2 p.m. - 6 p.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	6 p.m. - 10 p.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	
	10 p.m. - 6 a.m.		Total	Total	S M L S M L S M L S M L S M L S M L	Total	Total	Total	Total	

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