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MEDICAL PRODUCTS INC.

PATIENT LOG BOOK

TO BE USED WHEN WORKING WITH YOUR PHYSICIAN

FOR USE WITH THE ANORECTAL

BIOFEEDBACK MONITOR 10

FOR FECAL CONSTIPATION

Dear Patient:

The charts and information on the following pages will better assist your physician, if applicable, in designing the training program that is best for you. It is very important that you record any and all information diligently.

For at least one week before Biofeedback treatment has begun, you will be recording your personal experiences. The recording should be continued throughout the duration of your treatment program. It is important to record successful toilet visits as well as any episodes of constipation.

Be as specific as you can regarding the episodes of constipation. (i.e. Was it a painful bowel movement?, Was it accompanied by crampy abdominal pain?, How long has it been since your last bowel movement?, Was the bowel movement voluntary or involuntary?)

When your biofeedback training begins, record the date, number, and duration of sphincter exercises performed each day. Also record any other sphincter exercises that you perform during each day.

In creating your own personal record, you may simplify the entries by using the following suggested abbreviations or you may create your own. If you choose to create your own abbreviations, please write down what they stand for in the space provide below so that your physician will understand what you have recorded.

Suggested Abbreviations:

Voluntary Bowel Movement (successful toilet visit)	VBM
Episodes of constipation involving:	
Recurrent Abdominal Pain	AP
Lack of Urge to Defecate	LUD
Desire to Defecate	DD
Involuntary Bowel Movement	IBM
Formed stool	FS
Loose stool	LS
Medication (i.e. stool softeners)	MED
Enema	E
Clean	C
Biofeedback session	BF
Other sphincter muscle exercises	SE

Record Your Own Abbreviations Here:

COMPLETE THIS FORM YOURSELF (OR WITH YOUR PHYSICIAN)

Name: _____

Sex: _____ Age: _____

How long have you had a constipation problem? _____

Which of the following do you experience? (check any that apply for constipation)

☐ Discharge ☐ Soiling Urgency ☐ Gas

☐ Liquid ☐ Solid

How many bowel movements do you have per week? _____ per month? _____

What is the stool consistency? (check any that apply)

☐ Watery ☐ Loose ☐ Formed ☐ Hard

How many times a day do you feel the urge to defecate? _____

How many times a week do you feel the urge to defecate? _____

Is there a particular time of day or night when these episodes occur most often?

☐ Yes ☐ No

If so, when? _____

RELEVANT MEDICAL HISTORY

Please check any which apply directly to you.

- ☐ Grav/para status
- ☐ Diabetes
- ☐ Impotence
- ☐ Neurological disease
- ☐ Diarrhea medication
- ☐ Traumatic delivery
- ☐ GI surgery
- ☐ Hx a/r surgery
- ☐ Radiation
- ☐ Urinary incontinence
- ☐ Trauma to perineum

Other illnesses: _____

_____

List any medications that you are currently taking:

_____

_____

_____

List any medications that you have taken in the past (if not already listed) related to your constipation: _____

_____

_____

In the space below, record anything else that you consider relevant to your condition:

_____

_____

_____

_____

WEEK ONE – *Record episodes of constipation in detail*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME

WEEK ONE NOTES: _____

_____

_____

WEEK TWO – *Record episodes of constipation in detail & number of BF exercises and duration*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				

WEEK TWO NOTES: _____

WEEK THREE – *Record episodes of constipation in detail & number of BF exercises and duration*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				

WEEK THREE NOTES: _____

WEEK FOUR – *Record episodes of constipation in detail & number of BF exercises and duration*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				

WEEK FOUR NOTES: _____

_____

WEEK FIVE – *Record episodes of constipation in detail & number of BF exercises and duration*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				

WEEK FIVE NOTES: _____

_____

WEEK SIX – *Record episodes of constipation in detail & number of BF exercises and duration*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				
BF Qty. & Duration				

WEEK SIX NOTES: _____

_____

If you have any questions or problems regarding the use
or function of this device, please ask your doctor or contact
Biosearch Medical Products, Inc. at the address shown below:

biosearch®
MEDICAL PRODUCTS INC.

35 Industrial Parkway
Branchburg, NJ. 08876-1276 U.S.A.
Phone: 908-722-5000
Fax: 908-722-5024
http://www.biosearch.com

EC REP

Emerge Europe
Molenstraat 15
2513 BH The Hague
Netherlands
Phone: +31 (0)70 345 8570
Fax: +31 (0)70 346 7299

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