biosearch®
MEDICAL PRODUCTS INC.

PATIENT LOG BOOK

TO BE USED WHEN WORKING WITH YOUR PHYSICIAN

FOR USE WITH THE ANORECTAL BIOFEEDBACK MONITOR 5

FOR FECAL INCONTINENCE AND KEGEL EXERCISES

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 incontinent episodes.

Be as specific as you can regarding the incontinent episodes. (i.e. Did gas, urine or stool escape?, Was it a major or minor accident?) If it was stool that escaped, be sure to record whether it was loose or formed.

When your biofeedback training begins, record the date, number, and duration of sphincter exercises performed each day. Also record any other sphincter or Kegel 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
Incontinent episode involving either:	
Slightly Soiled perineum or underwear	SS
Heavily Soiled perineum or underwear	HS
Evacuation in underwear (Major Accident)	MA
Gas	GAS
Formed stool	FS
Loose stool	LS
Medication (i.e. stool softeners)	MED
Enema	E
Clean	C
Biofeedback session	BF
Other sphincter muscle or Kegel exercises	SE

Record Your Own Abbreviations Here:

____

____

____

____

____

____

____

____

COMPLETE THIS FORM YOURSELF (OR WITH YOUR PHYSICIAN)

Name: ______________________________

Sex: __________ Age: ________________

How long have you had an incontinence problem? ____________________________

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

☐ Discharge ☐ Soiling Urgency ☐ Gas

☐ Liquid ☐ Solid

How many bowel movements do you have per day? ____________________________

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

☐ Watery ☐ Loose ☐ Formed ☐ Hard

How many incontinence episodes do you experience per day? ____________________

How many incontinence episodes do you experience per week? ____________________

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 incontinence: ______________________________

____

____

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

____

____

____

____

WEEK ONE – *Record voluntary & involuntary bowel movements in detail*

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME

WEEK ONE NOTES: ______________________________

____

____

WEEK TWO – *Record voluntary & involuntary bowel movements 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 voluntary & involuntary bowel movements 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 voluntary & involuntary bowel movements 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 voluntary & involuntary bowel movements 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 voluntary & involuntary bowel movements 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:

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

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

© 2011 Biosearch Medical Products, Inc. All rights reserved

3944 Rev.07/11