

biobsearch®  
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:**

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## 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.

- |                                               |                                               |
|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Grav/para status     | <input type="checkbox"/> GI surgery           |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hx a/r surgery       |
| <input type="checkbox"/> Impotence            | <input type="checkbox"/> Radiation            |
| <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Diarrhea medication  | <input type="checkbox"/> Trauma to perineum   |
| <input type="checkbox"/> Traumatic delivery   |                                               |

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
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				

WEEK TWO NOTES: \_\_\_\_\_

\_\_\_\_\_

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

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				

WEEK THREE NOTES: \_\_\_\_\_

\_\_\_\_\_



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

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				

WEEK FOUR NOTES: \_\_\_\_\_

\_\_\_\_\_

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

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				

WEEK FIVE NOTES: \_\_\_\_\_

\_\_\_\_\_

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

DATE	MORNING	AFTERNOON	EVENING	NIGHT TIME
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				
<i>BF Qty. &amp; Duration</i>				

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®**

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