

biobsearch®  
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:**

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## 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.

- |   |   |
|---|---|
| <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 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
<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 voluntary & involuntary bowel movements 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 THREE NOTES: \_\_\_\_\_

\_\_\_\_\_



**WEEK FOUR** – Record voluntary & involuntary bowel movements 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 FOUR NOTES: \_\_\_\_\_

\_\_\_\_\_

**WEEK FIVE** – Record voluntary & involuntary bowel movements 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 voluntary & involuntary bowel movements 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 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<sup>®</sup>**  
**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



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