

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:

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. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & 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. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & 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. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & 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. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & 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. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & Duration</i>				
<i>BF Qty. & 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[®]
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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