

# TOILET DIARY







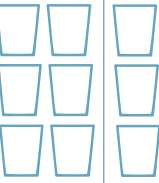





We know that it can feel strange talking about your toilet habits. It might help to keep a 'toilet diary' that you can just hand to your healthcare professional.

Print out this diary and fill it in for at least two weeks, just tick off the icons to keep track on how you are feeling.

These details will help the healthcare professional build up a picture of your health so that you can be treated properly.

Use of "Find our doctor" page to find a healthcare professional who understands OIC. Click here or use the below QR code.

QR CODE  
PLACEHOLDER

	Example entry	MON	TUES	WED	THURS	FRI	SAT	SUN
<b>1st pain medication:</b> <b>Dosage:</b> _____ <b>2nd pain medication:</b> <b>Dosage:</b> _____	Tick or shade in your answer Morning <input checked="" type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input checked="" type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>	Morning <input type="checkbox"/> <input type="checkbox"/> Lunch <input type="checkbox"/> <input type="checkbox"/> Afternoon <input type="checkbox"/> <input type="checkbox"/> Evening <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/>
<b>Did you eat any fruits or vegetables today? If so, tick when you did.</b> 	Breakfast <input checked="" type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input checked="" type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>	Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/>
<b>How much fluids have you had today?</b>  = 200ml								
<b>Have you completed any form of activity today? (walking counts)</b> 	Minutes 15 <input type="checkbox"/> 30 <input checked="" type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>	Minutes 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 75 <input type="checkbox"/> 90 <input type="checkbox"/>
<b>If you experience three or more of the below symptoms you may have OIC. Contact a healthcare professional</b>								
	Example entry	MON	TUES	WED	THURS	FRI	SAT	SUN
<b>What did you experience today?</b> 	<i>bloating</i>	bloating	bloating	bloating	bloating	bloating	bloating	bloating
	<i>abdominal pain</i>	abdominal pain	abdominal pain	abdominal pain	abdominal pain	abdominal pain	abdominal pain	abdominal pain
	<i>straining</i>	straining	straining	straining	straining	straining	straining	straining
	<i>unable to poo</i>	unable to poo	unable to poo	unable to poo	unable to poo	unable to poo	unable to poo	unable to poo
	<i>30+ mins spent on the toilet</i>	30+ mins spent on the toilet	30+ mins spent on the toilet	30+ mins spent on the toilet	30+ mins spent on the toilet	30+ mins spent on the toilet	30+ mins spent on the toilet	30+ mins spent on the toilet
	<i>other...</i>							