Week commencing: / /

IRRITABLE BOWEL SYNDROME PATIENT DIARY

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DIET							
Breakfast							
Lunch							
Dinner							
Snacks							
ABDOMINAL SYMPTOMS							
Pain	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Discomfort	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Bloating	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
BOWEL MOVEMENTS							
Shape/consistency	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
Number of bowel movements	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+
Sense of urgency	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
IBS-RELATED MEDICATIONS							
Non-prescription							
Prescription							
EMOTIONS							
IMPACT ON DAY/EVENTS							

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See reverse for further instructions and examples. This diary is not intended to substitute for professional medical assessment and/or advice. Always seek the advice of your physician or other qualified healthcare provider with any questions you may have regarding a medical condition.

IRRITABLE BOWEL SYNDROME PATIENT DIARY: INSTRUCTIONS

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A	**DIET**						
	Breakfast						
	Lunch						
	Dinner						
	Snacks						
B	**ABDOMINAL SYMPTOMS**						
	Pain	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
	Discomfort	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
	Bloating	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
C	**BOWEL MOVEMENTS**						
	Shape/consistency	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
	Number of bowel movements	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+	0 1 2 3 4+
	Sense of urgency	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
D	**IBS-RELATED MEDICATIONS**						
	Non-prescription						
	Prescription						
E	**EMOTIONS**						
F	**IMPACT ON DAY/EVENTS**						

A DIET

Please be as specific as possible, and include beverages. For example, **Breakfast:** coffee, whole-grain toast; **Lunch:** tomato soup, chocolate bar, herbal tea; **Dinner:** baked salmon with white rice and vegetables; **Snacks:** banana, yogurt, chips.

B ABDOMINAL SYMPTOMS

Please indicate your level of abdominal pain, discomfort, and/or bloating, where 0 = no pain, discomfort, and/or bloating and 5 = severe pain, discomfort, and/or bloating.

C BOWEL MOVEMENTS

Shape/consistency is based on the Bristol Stool Form Scale.* Use this scale to indicate your number, where 0 = no stool.

1	2	3	4	5	6	7
						
Separate hard lumps, like nuts.	Sausage-shaped but lumpy.	Like a sausage or snake but with cracks on the surface.	Like a sausage or snake, smooth and soft.	Soft blobs with clear-cut edges.	Fluffy pieces with ragged edges, a mushy stool.	Watery, no solid pieces.

D IBS-RELATED MEDICATIONS

Please include frequency of all prescription medications and non-prescription products used related to bowel habits. If you do not have enough room, please write on an additional sheet for your healthcare provider.

E EMOTIONS

Please describe any particular emotions you experienced, e.g., anxious, stressed, happy, depressed, relieved, frustrated.

F IMPACT ON DAY/EVENTS

Please record anything else you feel may be relevant, e.g., if you missed work or a family event because of your symptoms.

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