

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 | | | | | | | |
| | | | | | | | |

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.