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						
IBS-RELATED MEDICATIONS							
Non-prescription							
Prescription							
EMOTIONS							
IMPACT ON DAY/EVENTS							



IRRITABLE BOWEL SYNDROME PATIENT DIARY: INSTRUCTIONS

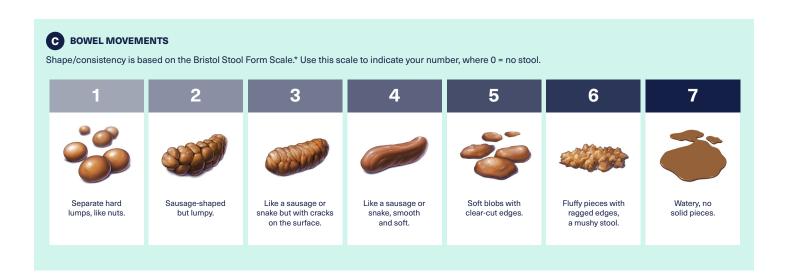
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DIET							
Breakfast							
Lunch							
Dinner							
Snacks							
ABDOMINAL SYMPTOMS							
Pain	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Discomfort	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	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						
IBS-RELATED MEDICATIONS							
Non-prescription							
Prescription							
EMOTIONS							
IMPACT ON DAY/EVENTS							



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.



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.



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



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



