OAB Therapy Tracking Sheet

Therapy being tried: _____

Primary Target: _____

How will you recognize success? _____

Trial start date: _____ **Planned trial period:** _____

Physician instructions: _____

_____

_____

Record observations that may help you evaluate your therapy trial. Include changes in your Primary Target, other symptoms or effects, and significant events or circumstances that may help you and your physician understand what happened and when. Do not assume that an event was caused by the therapy simply because it occurred during the trial. Record events that seem unusual or potentially important, even if you do not know whether they are related to the therapy.

If you wish to type in the form, you can convert the PDF to a Word Document or you may print it for handwritten observations.

Date / Time	Treatment or Activity	What I Observed	Other Events / Changes / Comments

OAB Therapy Completion Questionnaire

1. What therapy did you try?

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2. Why did you choose this therapy?

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3. What was your Primary Target when you began? Is it still your Primary Target?

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4. Compared with when you began, your Primary Target is:
Much Better / Better / About the Same / Worse / Much Worse

5. Did the therapy meet your definition of success?
Yes / Partly / No / Not Sure. Comment: _____

6. What other benefits, changes, or problems did you notice during the trial?

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7. Did you experience anything that you or your physician thought might be a side effect or otherwise related to the therapy?
Yes / No / Not Sure
If Yes or Not Sure, explain: _____

8. Were there significant events or changes during the trial that might have affected your symptoms or your evaluation of the therapy?

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9. What do you plan to do next?
Continue this therapy / Modify it after discussion with my physician / Try another approach / Stop treatment for now / Not yet decided / Other: _____

10. What do you want your physician to know about your experience with this therapy?
