

North Florida OBGYN - Urogynecology
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VOIDING / PVR DIARY

(Self-Catheterization)

PATIENT NAME: _____ DATE: _____

BEDTIME: _____ TIME YOU GOT UP FOR THE DAY: _____

TIME OF VOID	STRENGTH OF PAIN OR URGE (RATE 0 TO 10)	VOIDED VOLUME (CC)	CATHETER VOLUME PVR (CC)	COMMENTS OR ANY ADDITIONAL INFORMATION YOU CAN GIVE US