Date: ___/___/_____ **Ins and Outs** Name:_____

In: Food and Beverages:

time	item/amount	time	item/amount	time	item/amount
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
time	item/amount	time	item/amount	time	item/amount
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Out: Stools:

Total number all day/night: _____ How many in the night, after going to bed? _____

Type (circle all that apply):

Black and tarry/sticky Hard Medium/normal Soft/mushy Soupy Watery Foamy/floating Explosive

Blood (circle all that apply): On paper On stool Red water Clots (If female, date last period started: _____)

Symptoms (circle all that apply): Cramping Flatulence Urgency Smear on pants/pad Incontinence of stool

Pain before BM Pain during BM Pain after BM Location of pain: _____

Medications/supplements/treatments today (did they help?):	**Other notes** about today (stresses, successes, events, health...):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____