My Symptom Journal

NOTICE THE PATTERN. NAME THE EXPERIENCE. SHARE THE STORY.

Symptoms can be hard to remember and even harder to explain. Use this journal to capture what you feel, when it happens, and what may be connected. There is value in recording symptom-free days, too.

START WITH YOUR STORY

What feels different, or what are you hoping to understand?

When did you first notice it? Has it changed since then?

USE CLEAR SYMPTOM LANGUAGE

PAIN

Where is it? When did it start? Is it constant or does it come and go? Rate it 0-10.

☐ Sharp ☐ Dull ☐ Cramping ☐ Burning

☐ Aching ☐ Pressure ☐ Throbbing ☐ Other

BLEEDING

Note the source, amount, color, clots, and whether it was expected for you.

☐ Spotting ☐ Light ☐ Moderate ☐ Heavy

☐ Vaginal ☐ Urine ☐ Stool ☐ Unsure

BOWEL MOVEMENTS

Record how often you went, stool consistency, urgency, straining, pain, mucus, or blood.

☐ 1-2 hard/lumpy ☐ 3-4 formed ☐ 5-7 soft/liquid

URINATION

Track frequency, amount, urgency, pain or burning, leakage, blood, and nighttime trips.

☐ Urgency ☐ Burning ☐ Leakage ☐ Blood

Stool numbers refer to the Bristol Stool Form Scale: 1 is separate hard lumps; 7 is entirely liquid.

A FEW HELPFUL HABITS

- Check in around the same time each day.
- Record what happened before the symptom and what helped afterward.
- Bring several completed pages to your healthcare visit.
- Include medications, supplements, cycle timing, sleep, stress, food, activity, and sex when relevant.

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DAILY CHECK-IN

DATE: _____ TIME: _____ CYCLE / PERIOD DAY: _____

☐ Today I felt no symptoms — If checked, you can still complete Context + Notes below.

PAIN

Location: _____

Intensity (0-10): _____

☐ Sharp ☐ Dull ☐ Cramping

☐ Burning ☐ Aching ☐ Pressure

☐ Constant ☐ Comes + goes ☐ Worse

Started / lasted: _____

What helped: _____

BLEEDING

☐ None ☐ Spotting ☐ Light ☐ Moderate

☐ Heavy ☐ Clots ☐ Unexpected

Source: ☐ Vaginal ☐ Urine ☐ Stool ☐ Unsure

Color / clots: _____

Products used / changed: _____

Started / lasted: _____

Other details: _____

BOWEL MOVEMENTS

Number today: _____

Consistency: ☐ 1-2 ☐ 3-4 ☐ 5-7

☐ Easy ☐ Straining ☐ Urgent ☐ Pain

☐ Mucus ☐ Blood ☐ Incomplete ☐ Accident

Notes: _____

URINATION

Number today: _____

Nighttime trips: _____

☐ Urgency ☐ Burning ☐ Pain ☐ Leakage

☐ Blood ☐ Cloudy ☐ Strong odor ☐ Small amount

Notes: _____

OTHER SYMPTOMS + CONTEXT

☐ Bloating ☐ Nausea ☐ Fatigue ☐ Dizziness ☐ Fever/chills ☐ Discharge/odor

☐ Itching ☐ Headache ☐ Sleep change ☐ Mood change ☐ Appetite change

Food/drink, medication, activity, sex, sleep, stress, or anything else that may matter: _____

IMPACT + NOTES

How much did symptoms affect your day? ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot

One thing I want my healthcare professional to know: _____

GET URGENT HELP for severe or rapidly worsening symptoms, fainting, trouble breathing, severe bleeding, or if you feel unsafe.