MICHIGAN BOWEL CONTROL PROGRAM
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

GAS DIARY

Name: _____ Start Date: _____

Instructions: When you have gas, please fill in the letter(s) corresponding to what happened in the appropriate day and time box.

Key: G = Gas
I = Incontinence/Bowel accident with gas
M= Medication for gas taken
P = Pain with gas
S = Straining to pass gas

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Gas Meds
6am								
7am								
8am								
9am								
10am								
11am								
12pm								
1pm								
2pm								
3pm								
4pm								
5pm								
6pm								
7pm								
8pm								
9pm								
10pm								
11pm								
12am								
1am								
2am								
3am								
4am								
5am								

**This diary will be helpful to keep with the food diary. When noting gas symptoms, refer to the food diary to help find associations between foods and gas production.

Notes: _____

_____

_____

© 2015, The Regents of the University of Michigan