



PRINTED READINGS FORM

PLEASE COMPLETE IN BLOCK ONLY CAPITALS, IN BLACK INK AND INSERT ONLY X IN THE CHECKBOX FIELDS **X**

ABOUT THE SCREENING SITE

*1	Country	
*2	City/Town/Village name	
3	Site ID and/or email address	
4	Where is your screening site?	<input type="checkbox"/> Hospital/clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Workplace <input type="checkbox"/> Public area (outdoors) <input type="checkbox"/> Public area (indoors) <input type="checkbox"/> Other
*5	Date of measurement (dd/mm/yy)	/ /
*6	Time of measurement in 24hr clock format (e.g. 14:25)	:
7	Temperature at the site of screening	<input type="checkbox"/> °C <input type="checkbox"/> °F

ABOUT THE PARTICIPANT

*8	Please confirm that you understand that the data recorded is anonymous and you give your permission for your readings to be used for academic research purposes	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Ethnicity** (self-declared)	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> South Asian <input type="checkbox"/> East Asian <input type="checkbox"/> South-East Asian <input type="checkbox"/> Arabic <input type="checkbox"/> Hispanic (US ONLY) <input type="checkbox"/> Mixed <input type="checkbox"/> Other
10	Have you ever had your blood pressure measured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	If so, have you had your blood pressure measured in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Did you participate in May Measurement Month 2017?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Have you ever been diagnosed with high blood pressure by a health professional (except in pregnancy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Are you currently taking prescribed medication to treat high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
*15	How old are you in years? (Estimate if unknown)	<input type="checkbox"/> Mark with X if estimated
*16	What is your sex?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
17	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Are you currently fasting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19	Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
20	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21	Do you consume alcohol?	<input type="checkbox"/> Never / rarely <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> At least once per week
22	Have you had a heart attack in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
23	Have you had a stroke in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

MEASUREMENTS

24	Weight (estimate if not measured)	Kilograms (kg) OR Pounds (lbs)	<input type="checkbox"/> Mark with X if estimated
25	Height (estimate if not measured)	' " Feet & inches OR Centimeters (cm)	<input type="checkbox"/> Mark with X if estimated
26	What type of BP machine is being used to take the readings?	<input type="checkbox"/> Automated <input type="checkbox"/> Not automated	
27	What is the manufacturer name and model type?		
28	Which arm is being used to take the blood pressure?	<input type="checkbox"/> Left <input type="checkbox"/> Right	
		Systolic Blood Pressure (SBP)	Diastolic Blood Pressure (DBP)
*29	1st measurement		Heart rate
30	2nd measurement		
31	3rd measurement		

* These questions must be answered in order to be submitted for May Measurement Month

NB: Do not record any personal data that would identify the patient e.g. name, address.

** South Asian – with origins of: India, Pakistan, Bangladesh, Nepal, Bhutan, Maldives and Sri Lanka

East Asian – with origins of: Mainland China, Hong Kong, Macau, Taiwan, Japan, Mongolia, North Korea and South Korea, China, Hong Kong, Japan, Macau, Mongolia, North Korea, South Korea, Taiwan

South-East Asian – with origins of: Cambodia, Laos, Myanmar (Burma), Thailand, Vietnam and Malaysia, Brunei (on the island of Borneo), Indonesia, the Philippines, Singapore and East Timor