My BP Medications:

Drug name, strength, directions

1.

2.

3.

4.

5.

Please show this Tracker at the drop off window when you come for appointments.

My BP Tracker

TEAM Program:
Working Together for Healthy Blood Pressure

Name:_____

Pharmacist:_____

Technician:_____

Pharmacy Tel: _____

My BP Medications:

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My BP Tracker

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Name:_____

Pharmacist:_____

Technician:_____

Pharmacy Tel: _____

Date	Blood Pressure	Date	Blood Pressure

My blood pressure goal is:
Less than_____/_____

Date	Blood Pressure	Date	Blood Pressure

My blood pressure goal is:
Less than_____/_____

Date	Blood Pressure	Date	Blood Pressure

My blood pressure goal is:
Less than_____/_____