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: _____

(Fold to create wallet-size BP Tracker. Encourage patient to record BP readings)

Date	Blood Pressure	Date	Blood Pressure

My blood pressure goal is: Less than_____/_____