

My BP Medications:

Drug name, strength, directions

- 1.
- 2.
- 3.
- 4.
- 5.

My BP Tracker



**TEAM Program:
Working Together for
Healthy Blood Pressure**

Name: _____

Pharmacist: _____

Technician: _____

Pharmacy Tel: _____

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

(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 _____/_____

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