Patient Name: _____ Patient Study ID __ __ __ __

Site ID: __ __ Interviewer ID: _____ Date: _____

Brief Medication Questionnaire 2 (BMQ 2)

This form asks about the prescription medications you currently take for high blood pressure. I will read the questions on p. 1 and ask you to read and answer the other pages by yourself.

1. **How many medications do you currently take for high blood pressure, including water pills?**
   _____ medication(s)

2. **Do you have the medication bottle(s) available for me to see?**
   ❑ Yes ❑ No

3. **What is the name of each medication?** *(Interviewer: print medication names on pages 2 through 6 and add extra pages if needed.)*

Name or description of each blood pressure medication	*Leave blank*
Drug A:	
Drug B:	
Drug C:	
Drug D:	
Drug E:	

4. **<u>In the past six months</u>, did your doctor make any of the following changes in your blood pressure (BP) medication(s)?** *Please check "yes" or "no" for each item.*

In the past six months, did your doctor…	**Yes**	**No**	**If yes: what medications?**	*Leave blank*
a. Stop any BP medications?	❑	❑		
b. Start any new BP medications?	❑	❑		
c. Increase the dose, strength, or how much you take each day?	❑	❑		
d. Decrease the dose, strength, or how much you take each day?	❑	❑		
e. Make any other changes? *Specify:* _____	❑	❑		

The following questions ask about your use of certain medication(s) in the PAST WEEK. Please answer the questions for each drug listed.

Drug A: _____

1. How often does your doctor want you to take this drug?	❑ Every day / daily ❑ As needed ❑ Don't know
2. How is this drug supposed to help you? *(Please check all that apply.)*	❑ Get rid of water ❑ Lower my pressure ❑ Prevent a stroke ❑ Prevent heart problems ❑ Relieve headaches ❑ Other: _____ ❑ Don't know
3. In the <u>PAST WEEK</u>	
a. Did you take **<u>any</u>** of this drug?	❑ Yes ❑ No
b. How many **<u>days</u>** did you take this drug? (circle)	I took it: 0 1 2 3 4 5 6 7 days
c. How many **<u>times a day</u>** did you usually take it?	I took it: 0 1 2 3 times a day
d. How much did you usually take each time?	I took: 0 pills, ½ pill, 1 pill, 2 pills, 3 pills each time
e. How many times did you MISS taking it?	I missed it: 0 1 2 3 4 5 6 7 times
4. How well does this drug work for you?	❑ Not at all well ❑ Moderately well ❑ Very well ❑ Don't know
5. How much does this drug bother you?	❑ Not at all ❑ Bothers a little ❑ Bothers a lot ❑ Don't know

6. How much difficulty are you having in each area? *(Circle a number for each item)*	**None**	**A little**	**A lot**
a. It is hard to remember all the doses	0	1	2
b. It is hard to pay for this drug	0	1	2
c. It is hard to get my refill on time	0	1	2
d. I still get unwanted side effects from this drug.	0	1	2
e. I worry about the long-term effects of this drug.	0	1	2
f. This drug causes other concerns or problems.	0	1	2

Drug B: _____

1. How often does your doctor want you to take this drug?	❑ Every day / daily ❑ As needed ❑ Don't know
2. How is this drug supposed to help you? *(Please check all that apply.)*	❑ Get rid of water ❑ Lower my pressure ❑ Prevent a stroke ❑ Prevent heart problems ❑ Relieve headaches ❑ Other: _____ ❑ Don't know
3. In the <u>PAST WEEK</u>	
a. Did you take **<u>any</u>** of this drug?	❑ Yes ❑ No
b. How many **<u>days</u>** did you take this drug? (circle)	I took it: 0 1 2 3 4 5 6 7 days
c. How many **<u>times a day</u>** did you usually take it?	I took it: 0 1 2 3 times a day
d. How much did you usually take each time?	I took: 0 pills, ½ pill, 1 pill, 2 pills, 3 pills each time
e. How many times did you MISS taking it?	I missed it: 0 1 2 3 4 5 6 7 times
4. How well does this drug work for you?	❑ Not at all well ❑ Moderately well ❑ Very well ❑ Don't know
5. How much does this drug bother you?	❑ Not at all ❑ Bothers a little ❑ Bothers a lot ❑ Don't know

6. How much difficulty are you having in each area? *(Circle a number for each item)*	**None**	**A little**	**A lot**
a. It is hard to remember all the doses	0	1	2
b. It is hard to pay for this drug	0	1	2
c. It is hard to get my refill on time	0	1	2
d. I still get unwanted side effects from this drug.	0	1	2
e. I worry about the long-term effects of this drug.	0	1	2
f. This drug causes other concerns or problems.	0	1	2

Drug C: _____

1. How often does your doctor want you to take this drug?	❑ Every day / daily ❑ As needed ❑ Don't know
2. How is this drug supposed to help you? *(Please check all that apply.)*	❑ Get rid of water ❑ Lower my pressure ❑ Prevent a stroke ❑ Prevent heart problems ❑ Relieve headaches ❑ Other: _____ ❑ Don't know
3. In the <u>PAST WEEK</u>	
a. Did you take **<u>any</u>** of this drug?	❑ Yes ❑ No
b. How many **<u>days</u>** did you take this drug? (circle)	I took it: 0 1 2 3 4 5 6 7 days
c. How many **<u>times a day</u>** did you usually take it?	I took it: 0 1 2 3 times a day
d. How much did you usually take each time?	I took: 0 pills, ½ pill, 1 pill, 2 pills, 3 pills each time
e. How many times did you MISS taking it?	I missed it: 0 1 2 3 4 5 6 7 times
4. How well does this drug work for you?	❑ Not at all well ❑ Moderately well ❑ Very well ❑ Don't know
5. How much does this drug bother you?	❑ Not at all ❑ Bothers a little ❑ Bothers a lot ❑ Don't know

6. How much difficulty are you having in each area? *(Circle a number for each item)*	**None**	**A little**	**A lot**
a. It is hard to remember all the doses	0	1	2
b. It is hard to pay for this drug	0	1	2
c. It is hard to get my refill on time	0	1	2
d. I still get unwanted side effects from this drug.	0	1	2
e. I worry about the long-term effects of this drug.	0	1	2
f. This drug causes other concerns or problems.	0	1	2

Drug D: _____

1. How often does your doctor want you to take this drug?	❑ Every day / daily ❑ As needed ❑ Don't know
2. How is this drug supposed to help you? *(Please check all that apply.)*	❑ Get rid of water ❑ Lower my pressure ❑ Prevent a stroke ❑ Prevent heart problems ❑ Relieve headaches ❑ Other: _____ ❑ Don't know
3. In the <u>PAST WEEK</u>	
a. Did you take **<u>any</u>** of this drug?	❑ Yes ❑ No
b. How many **<u>days</u>** did you take this drug? (circle)	I took it: 0 1 2 3 4 5 6 7 days
c. How many **<u>times a day</u>** did you usually take it?	I took it: 0 1 2 3 times a day
d. How much did you usually take each time?	I took: 0 pills, ½ pill, 1 pill, 2 pills, 3 pills each time
e. How many times did you MISS taking it?	I missed it: 0 1 2 3 4 5 6 7 times
4. How well does this drug work for you?	❑ Not at all well ❑ Moderately well ❑ Very well ❑ Don't know
5. How much does this drug bother you?	❑ Not at all ❑ Bothers a little ❑ Bothers a lot ❑ Don't know

6. How much difficulty are you having in each area? *(Circle a number for each item)*	**None**	**A little**	**A lot**
a. It is hard to remember all the doses	0	1	2
b. It is hard to pay for this drug	0	1	2
c. It is hard to get my refill on time	0	1	2
d. I still get unwanted side effects from this drug.	0	1	2
e. I worry about the long-term effects of this drug.	0	1	2
f. This drug causes other concerns or problems.	0	1	2

Drug E: _____

1. How often does your doctor want you to take this drug?	❑ Every day / daily ❑ As needed ❑ Don't know
2. How is this drug supposed to help you? *(Please check all that apply.)*	❑ Get rid of water ❑ Lower my pressure ❑ Prevent a stroke ❑ Prevent heart problems ❑ Relieve headaches ❑ Other: _____ ❑ Don't know
3. In the <u>PAST WEEK</u>	
a. Did you take **<u>any</u>** of this drug?	❑ Yes ❑ No
b. How many **<u>days</u>** did you take this drug? (circle)	I took it: 0 1 2 3 4 5 6 7 days
c. How many **<u>times a day</u>** did you usually take it?	I took it: 0 1 2 3 times a day
d. How much did you usually take each time?	I took: 0 pills, ½ pill, 1 pill, 2 pills, 3 pills each time
e. How many times did you MISS taking it?	I missed it: 0 1 2 3 4 5 6 7 times
4. How well does this drug work for you?	❑ Not at all well ❑ Moderately well ❑ Very well ❑ Don't know
5. How much does this drug bother you?	❑ Not at all ❑ Bothers a little ❑ Bothers a lot ❑ Don't know

6. How much difficulty are you having in each area? *(Circle a number for each item)*	**None**	**A little**	**A lot**
a. It is hard to remember all the doses	0	1	2
b. It is hard to pay for this drug	0	1	2
c. It is hard to get my refill on time	0	1	2
d. I still get unwanted side effects from this drug.	0	1	2
e. I worry about the long-term effects of this drug.	0	1	2
f. This drug causes other concerns or problems.	0	1	2