Patient Name: __________________________  Patient Study ID __ __ __ __
Site ID: __ __     Interviewer ID: __________   Date: _______________

Brief Medication Questionnaire 3 (BMQ 3)

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.)

<table>
<thead>
<tr>
<th>Name or description of each blood pressure medication</th>
<th>Leave blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug A:</td>
<td></td>
</tr>
<tr>
<td>Drug B:</td>
<td></td>
</tr>
<tr>
<td>Drug C:</td>
<td></td>
</tr>
<tr>
<td>Drug D:</td>
<td></td>
</tr>
<tr>
<td>Drug E:</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In the past six months, did your doctor...</th>
<th>Yes</th>
<th>No</th>
<th>If yes: what medications?</th>
<th>Leave blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stop any BP medications? ............</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Start any new BP medications? ......</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Increase the dose, strength, or how much you take each day? ............</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Decrease the dose, strength, or how much you take each day? ............</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Make any other changes? Specify:</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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 PAST WEEK

   a. Did you take any of this drug?  
      - Yes  
      - No

   b. How many days did you take this drug? (circle)  
      I took it:  0  1  2  3  4  5  6  7  days

   c. How many times a day 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)

<table>
<thead>
<tr>
<th>Area</th>
<th>None</th>
<th>A little</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. It is hard to remember all the doses</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. It is hard to pay for this drug</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. It is hard to get my refill on time</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. I still get unwanted side effects from this drug.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. I worry about the long-term effects of this drug.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f. This drug causes other concerns or problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
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 PAST WEEK**
   - a. Did you take **any** of this drug?
     - [ ] Yes  [ ] No
   - b. How many **days** did you take this drug? (circle)
     - I took: 0 1 2 3 4 5 6 7 days
   - c. How many **times a day** did you usually take it?
     - I took: 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)*

<table>
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<td>2</td>
</tr>
<tr>
<td>c. It is hard to get my refill on time</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. I still get unwanted side effects from this drug</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. I worry about the long-term effects of this drug</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f. This drug causes other concerns or problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
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 PAST WEEK
   a. Did you take any of this drug?
      - Yes
      - No
   b. How many days did you take this drug? (circle)
      I took it: 0 1 2 3 4 5 6 7 days
   c. How many times a day 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)
   
<table>
<thead>
<tr>
<th>Area</th>
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<tr>
<td>b. It is hard to pay for this drug</td>
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<td>2</td>
</tr>
<tr>
<td>c. It is hard to get my refill on time</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. I still get unwanted side effects from this drug.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. I worry about the long-term effects of this drug.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f. This drug causes other concerns or problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
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 PAST WEEK
   a. Did you take any of this drug?
      - Yes  No
   b. How many days did you take this drug? (circle)
      - I took it: 0 1 2 3 4 5 6 7 days
   c. How many times a day 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 PAST WEEK
   a. Did you take any of this drug?
      - [ ] Yes
      - [ ] No
   b. How many days did you take this drug? (circle)
      I took it: 0 1 2 3 4 5 6 7 days
   c. How many times a day 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)  

<table>
<thead>
<tr>
<th>Area</th>
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<tr>
<td>b. It is hard to pay for this drug</td>
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<tr>
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<td>2</td>
</tr>
<tr>
<td>d. I still get unwanted side effects from this drug.</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. I worry about the long-term effects of this drug.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f. This drug causes other concerns or problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>