1. What medications do you currently take for your blood pressure? LIST DRUGS HERE

2. How does your doctor want you to take this drug?
   - 1 every day
   - 2 as needed
   - 3 don’t know

3. How is this drug supposed to help you?
   (CIRCLE ALL THAT APPLY)
   - 1 get rid of water
   - 2 lower my pressure
   - 3 prevent a stroke
   - 4 prevent heart problem
   - 5 relieve headaches
   - 6 other 
   - 7 don’t know

4. IN THE PAST WEEK...
   a. how many days did you use this drug? .......... 0 1 2 3 4 5 6 7 days
   b. how many times a day did you use it? .......... 0 1 2 3 time(s) a day
   c. how much did you use each time? ............ 0 ½ 1 2 3 pill(s)
   d. how many times did you MISS taking it? ........ 0 1 2 3 4 5 6 7 time(s)

5. How well does this drug work for you?
   - 0 not at all well
   - 1 moderately well
   - 2 very well
   - 3 don’t know

6. Does this drug bother you in any way?
   - 0 No
   - 1 Yes

7. What kinds of concerns or problems are you having with it? If none, write ‘0’
   - None
   - A little
   - A lot

8. How much difficulty are you having in each area?
   - 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

9. Have you had any of the following problems in the past 30 days? Check all that apply to you.

   - □ Dizziness
   - □ Headaches
   - □ Shortness of breath
   - □ Feeling tired
   - □ Thumping/racing heart
   - □ Feel weak when I stand

   - □ Feeling depressed
   - □ Frequent thirst
   - □ Frequent urination
   - □ Dry mouth

   - □ Numb/tingling hands
   - □ Leg pain or swelling
   - □ Leg cramps
   - □ Cold hands or feet

   - □ Less interest in sex
   - □ Unable to get erection
   - □ Difficulty sleeping
   - □ Difficulty breathing
   - □ Constipation
   - □ Diarrhea

   - □ Rash or hives
   - □ Dry, hacking cough

   - □ Loss of taste
   - □ Blurry vision

   - □ Constipation
   - □ Diarrhea

   ► Are any of these problems caused by your blood pressure medication? □ No □ Yes □ Don’t know
10. Do you take any other medications for your blood pressure? If yes, please list other drugs here ►

<table>
<thead>
<tr>
<th>Drug 3</th>
<th>Drug 4</th>
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<tr>
<td>1 every day</td>
<td>1 every day</td>
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<td>2 as needed</td>
<td>2 as needed</td>
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<tr>
<td>3 don’t know</td>
<td>3 don’t know</td>
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11. How does your doctor want you to take this drug?

| 1 every day | 1 every day |
| 2 as needed | 2 as needed |
| 3 don’t know | 3 don’t know |

12. How is this drug supposed to help you?

(CIRCLE ALL THAT APPLY)

| 1 get rid of water | 1 get rid of water |
| 2 lower my pressure | 2 lower my pressure |
| 3 prevent a stroke | 3 prevent a stroke |
| 4 prevent heart problem | 4 prevent heart problem |
| 5 relieve headaches | 5 relieve headaches |
| 6 other _____________ | 6 other _____________ |
| 7 don’t know | 7 don’t know |

13. IN THE PAST WEEK…

a. how many days did you use this drug? ………

b. how many times a day did you use it? ………

c. how much did you use each time? ……………

d. how many times did you MISS taking it? ……

(If none, circle ‘0’)

| 0 1 2 3 4 5 6 7 days | 0 1 2 3 4 5 6 7 days |
| 0 1 2 3 time(s) a day | 0 1 2 3 time(s) a day |
| 0 1 2 3 pill(s) | 0 1 2 3 pill(s) |
| 0 1 2 3 4 5 6 7 time(s) | 0 1 2 3 4 5 6 7 time(s) |

14. How well does this drug work for you?

| 0 not at all well | 0 not at all well |
| 1 moderately well | 1 moderately well |
| 2 very well | 2 very well |
| 3 don’t know | 3 don’t know |

15. Does this drug bother you in any way?

| 0 No | 0 No |
| 1 Yes | 1 Yes |

16. What kinds of concerns or problems are you having with it? (If none, write ‘0’)

<table>
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<tr>
<th>None</th>
<th>A little</th>
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17. How much difficulty are you having in each area?

a. It is hard to remember all the doses………………

b. It is hard to pay for this drug…………………

c. It is hard to get my refill on time………………

d. I still get unwanted side effects from this drug……

e. I worry about the long term effects of this drug…

f. This drug causes other concerns or problems……

Thank you!