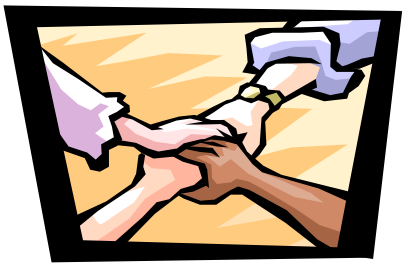
Name: _____ DOB: _____ Date: _____



TEAM PROGRAM: Working Together for Healthy Blood Pressure (BP)

Health Checklist (HC) – Visit 1

Dear Patient:

Welcome to the TEAM Program. Our goal is to work together as a team with you and your doctor to keep your blood pressure (BP) in the healthy range.

This Health Checklist will help us to evaluate your blood pressure medication(s) and your goals for the next six months.

If you are not sure how to answer a question, just skip it and we will assist you.

Thank you for your help!

[Insert your pharmacy name, logo, and research partners as illustrated below]

Walgreens

In collaboration with:

SCHOOL OF PHARMACY University of Wisconsin-Madison

MEDICAL COLLEGE OF WISCONSIN

A. YOUR HEALTH HISTORY

1. Have you **ever** had the following conditions? Check ☑ all the boxes that apply.

☐ Diabetes	☐ Weak or failing kidneys
☐ A heart attack	☐ Kidney dialysis
☐ Congestive heart failure	☐ Narrowing of the arteries
☐ Enlarged heart	☐ Speech difficulty
☐ Angina (chest pain)	☐ Weakness on one side
☐ A coronary bypass	☐ Slurred speech
☐ A stroke	☐ Loss of balance
☐ High cholesterol	☐ Faint or lose consciousness

2. Have you had the following problems in the past 30 days? Check all that apply.

☐ Dizziness	☐ Numbness, tingling of hands
☐ Headaches	☐ Leg pain or swelling
☐ Shortness of breath	☐ Leg cramps
☐ Feeling tired	☐ Cold hands or feet
☐ Thumping or racing heart	☐ Difficulty breathing
☐ Feel weak when I stand up	☐ Dry, hacking cough
☐ Feeling depressed or blue	☐ Decreased interest in sex
☐ Frequent thirst	☐ Unable to get an erection
☐ Frequent urination	☐ Difficulty sleeping
☐ Dry mouth	☐ Rash or hives
☐ Loss of taste	☐ Constipation or diarrhea
☐.Blurry vision	☐ Other → SPECIFY: _____

► Are any of these problems caused or made worse by your blood pressure medication?
☐ Yes ☐ No ☐ Don't know ☐ No problems in past 30 days

3. Has your doctor ever told you to avoid brisk walking or exercise? ☐Yes ☐ No

4. What is your height? ___feet ___ inches. What is your weight? ____pounds

5. Would you like to: ☐ lose weight ☐ gain weight ☐ stay the same

6. Do you smoke? ☐Yes ☐ No

B. YOUR LIFESTYLE AND SELF-CARE

	How often do you…	A. Usually/ often	B. Sometimes	C. Rarely/ never
	1.Take your medication at the same time(s) every day?	☐	☐	☐
	2. Use a pill box to help remember your medication?	☐	☐	☐
	3. Keep your medication where you will be reminded to take it ?	☐	☐	☐
	4. Do brisk walking or exercise at least 30 minutes a day, most days of the week?	☐	☐	☐
	5. Follow a low-sodium diet?	☐	☐	☐
	6. Use food labels to compare sodium content in foods?	☐	☐	☐
	7. Taste before adding salt to food at the table?	☐	☐	☐
	8. Eat low-salt snacks instead of salty chips or nuts?	☐	☐	☐
	9. Limit high-salt foods like frozen or packaged dinners and pizza?	☐	☐	☐
	10. Eat less than three fast food or take out meals a week?	☐	☐	☐
	11. Eat at least 4 servings of fruit a day? Serving= ½ cup fruit, 1 medium fruit, ¼ cup dried fruit, 6 oz juice	☐	☐	☐
	12. Eat at least 4 servings of vegetables a day? Serving= 1 cup leafy raw vegetables, ½ cup vegetables, 6 oz juice.	☐	☐	☐
	13. Use low-fat dairy food like 1% or skim milk or fat-free yogurt?	☐	☐	☐
	14. Eat lean meat, poultry, and fish instead of higher fat red meat	☐	☐	☐
	15. Limit foods with lots of sugar like pie, candy, ice cream, soda	☐	☐	☐
	16. Eat smaller portions to lose or keep normal weight?	☐	☐	☐
	17. Limit your use of alcohol (men: no more than 2 drinks a day; women: no more than 1 drink a day)? One drink= 12 oz. beer, 5 oz. wine, 1 shot of hard liquor.	☐	☐	☐
	18. Check your blood pressure at least one a month?	☐	☐	☐
	19. Write down your blood pressure numbers?	☐	☐	☐

C. YOUR BLOOD PRESSURE GOALS

1. Did your doctor ever tell you what your blood pressure numbers should be? ☐ Yes ☐ No

2. What do you think your blood pressure numbers should be?

☐ My blood pressure numbers should be ____/____ or lower
☐ I don't know

3. How concerned are you about your blood pressure level at this time?

☐ Very concerned ☐ Somewhat concerned ☐ Not at all concerned

4. Look back at YOUR LIFESTYLE AND SELF-CARE (page 3). Do you have any answers in Column A? If so, good for you!! You already are taking some steps to help lower your blood pressure and protect your heart. Now, think about <u>your goals for the next six months</u>.

5. Are you willing to get your blood pressure checked and meet briefly with your TEAM pharmacist once a month for six months, if needed? ☐ Yes ☐ No

6. What changes would you like to make in your medication, physical activity, eating habits, or other things you can do to help lower your blood pressure? Please list these changes in the boxes below.

	Changes I would like to make in the next 6 months
A.	
B.	
C.	