Thank you for participating in this survey. The following questions ask about your health history, beliefs about high blood pressure, use of services, and background information. If you have a question, you may circle the question number and leave it blank. A researcher will check the survey, clarify any questions, and give you the gift card before you leave.

Thank you for your help!
1. On average, how long does it take you to travel from your home to this pharmacy?
   - Less than 10 minutes
   - 10–19 minutes
   - 20–29 minutes
   - 30 or more minutes

2. How do you usually get to this pharmacy?
   - My own car
   - Someone else's car
   - Bus or train
   - Taxi
   - Walk or bicycle

3. Do you ever have to pay for transportation to get to this pharmacy?
   - Yes
   - No → SKIP TO QUESTION 5

4. When you have to pay for transportation to get to this pharmacy, how much does it cost, one-way?
   - $2.00 or less
   - $2.01–$5.00
   - More than $5.00

5. How long have you been coming to this pharmacy for your blood pressure medication?
   - Less than one year
   - 1–2 years
   - More than 2 years
   - Don't remember
B. HEALTH HISTORY

6. Have you ever been told by a doctor or other health professional that you had...

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Diabetes or sugar diabetes?</td>
<td>1</td>
</tr>
<tr>
<td>b. A heart attack?</td>
<td>1</td>
</tr>
<tr>
<td>c. Congestive heart failure?</td>
<td>1</td>
</tr>
<tr>
<td>d. Enlarged heart?</td>
<td>1</td>
</tr>
<tr>
<td>e. Angina (chest pain)?</td>
<td>1</td>
</tr>
<tr>
<td>f. A coronary bypass?</td>
<td>1</td>
</tr>
<tr>
<td>g. A stroke?</td>
<td>1</td>
</tr>
<tr>
<td>h. High cholesterol?</td>
<td>1</td>
</tr>
<tr>
<td>i. Weak or failing kidneys?</td>
<td>1</td>
</tr>
<tr>
<td>j. Kidney dialysis?</td>
<td>1</td>
</tr>
<tr>
<td>k. Narrowing of the arteries?</td>
<td>1</td>
</tr>
<tr>
<td>l. Speech difficulty?</td>
<td>1</td>
</tr>
<tr>
<td>m. Weakness on one side?</td>
<td>1</td>
</tr>
<tr>
<td>n. Slurred speech?</td>
<td>1</td>
</tr>
<tr>
<td>o. Loss of balance?</td>
<td>1</td>
</tr>
<tr>
<td>p. Fainting or losing consciousness?</td>
<td>1</td>
</tr>
</tbody>
</table>

7. Did your mother die from or suffer a heart attack or stroke before she was 65 years old?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

8. Did your father die from or suffer a heart attack or stroke before he was 55 years old?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

9. Do you now take diabetic pills or insulin for diabetes?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

10. Within the past 30 days, have you had the following problems?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Dizziness</td>
<td>1</td>
</tr>
<tr>
<td>b. Headaches</td>
<td>1</td>
</tr>
<tr>
<td>c. Shortness of breath</td>
<td>1</td>
</tr>
<tr>
<td>d. Feeling tired</td>
<td>1</td>
</tr>
<tr>
<td>e. Thumping or racing heart</td>
<td>1</td>
</tr>
<tr>
<td>f. Feeling weak when I stand up</td>
<td>1</td>
</tr>
<tr>
<td>g. Feeling depressed or blue</td>
<td>1</td>
</tr>
<tr>
<td>h. Frequent thirst</td>
<td>1</td>
</tr>
<tr>
<td>i. Frequent urination</td>
<td>1</td>
</tr>
<tr>
<td>j. Dry mouth</td>
<td>1</td>
</tr>
<tr>
<td>k. Loss of taste</td>
<td>1</td>
</tr>
<tr>
<td>l. Blurry vision</td>
<td>1</td>
</tr>
<tr>
<td>m. Numbness, tingling of hands</td>
<td>1</td>
</tr>
<tr>
<td>n. Leg pain or swelling</td>
<td>1</td>
</tr>
<tr>
<td>o. Leg cramps</td>
<td>1</td>
</tr>
<tr>
<td>p. Cold hands or feet</td>
<td>1</td>
</tr>
<tr>
<td>q. Difficulty breathing</td>
<td>1</td>
</tr>
<tr>
<td>r. Dry, hacking cough</td>
<td>1</td>
</tr>
<tr>
<td>s. Decreased interest in sex</td>
<td>1</td>
</tr>
<tr>
<td>t. Unable to get an erection</td>
<td>1</td>
</tr>
<tr>
<td>u. Difficulty sleeping</td>
<td>1</td>
</tr>
<tr>
<td>v. Rash or hives</td>
<td>1</td>
</tr>
<tr>
<td>w. Constipation or diarrhea</td>
<td>1</td>
</tr>
<tr>
<td>x. Other → SPECIFY:</td>
<td>1</td>
</tr>
</tbody>
</table>
C. YOUR HIGH BLOOD PRESSURE & LIFESTYLE

11. How long have you been taking medication for high blood pressure?
   - [ ] Less than one year
   - [ ] 1–2 years
   - [ ] More than 2 years
   - [ ] Don't know

12. Has your doctor or health care provider ever told you what your blood pressure GOAL should be?
   - [ ] Yes, he/she told me my blood pressure numbers should be: _____/_____.
   - [ ] Yes, he/she gave me a blood pressure goal, but I do not remember the numbers.
   - [ ] No, he/she has never told me what my blood pressure numbers should be.
   - [ ] I don't remember.

13. What do you think your blood pressure numbers should be?
   - [ ] I think my blood pressure numbers should be: _____/_____.
   - [ ] I don't know what my blood pressure numbers should be.

14. What do you think about your blood pressure level today? Do you think it was...
   - [ ] High
   - [ ] Borderline high
   - [ ] Normal/OK
   - [ ] Low
   - [ ] Don't know

15. How often can you tell by the way you feel that your blood pressure is too high?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Usually
   - [ ] Always

16. How concerned are you about your blood pressure level at this time?
   - [ ] Very concerned
   - [ ] Somewhat concerned
   - [ ] A little concerned
   - [ ] Not at all concerned
17. Following are some medical guidelines for lowering blood pressure. In columns I and II, please check how hard and how helpful you think it would be for you to follow each guideline, even if you have not tried to follow this guideline.

<table>
<thead>
<tr>
<th>I. How hard do you think it would be for you to follow this guideline?</th>
<th>II. How helpful do you think it would be for you to follow this guideline?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Very hard</td>
<td>□ Very helpful</td>
</tr>
<tr>
<td>□ Moderately hard</td>
<td>□ Moderately helpful</td>
</tr>
<tr>
<td>□ Not at all hard</td>
<td>□ Not at all helpful</td>
</tr>
</tbody>
</table>

a. Reduce the salt or sodium in your diet if needed
b. Walk or exercise 30 minutes per day 5 days a week
c. Eat 5 or more servings of vegetables and fruit a day
d. Maintain normal weight or lose weight if needed
e. Use alcohol in moderation (no more than 1-2 drinks per day)
f. Take blood pressure medication every day

18. Do you currently use the following methods for remembering your blood pressure medication?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I use a 7-day pill box</td>
<td>1</td>
<td>2</td>
<td>e. I take pills before or after a daily routine (e.g., brushing teeth, eating, going to bed)</td>
</tr>
<tr>
<td>b. I use another type of box</td>
<td>1</td>
<td>2</td>
<td>f. I keep my pills where I can see them</td>
</tr>
<tr>
<td>c. I carry my pills with me</td>
<td>1</td>
<td>2</td>
<td>g. I use a watch with alarm(s)</td>
</tr>
<tr>
<td>d. I take my pills at the same time(s) each day</td>
<td>1</td>
<td>2</td>
<td>h. Other → SPECIFY:</td>
</tr>
</tbody>
</table>

19. Do you currently use the following methods for monitoring your health and lifestyle?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I use a blood pressure monitor to check my blood pressure at home</td>
<td>1</td>
<td>2</td>
<td>b. I use a special card to keep track of my blood pressure readings</td>
</tr>
<tr>
<td>c. I check food labels to help control or reduce the salt or sodium in my diet</td>
<td>1</td>
<td>2</td>
<td>d. I use a pedometer or step-counter to help stay active or monitor my walking</td>
</tr>
</tbody>
</table>
20. Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to work and other places, and any other walking you do for recreation, sport, exercise, or leisure.

   In the last 7 days, about how many days did you walk at least 30 minutes per day? (IF NONE, WRITE '0' ON THE LINE.)
   _____ Days

21. Next, think about the time you spent doing other aerobic physical activities in the last 7 days. This includes any activity that takes physical effort and makes you breathe harder than normal (e.g., bicycling, water aerobics, basketball, dancing fast, washing floors, heavy lifting).

   In the last 7 days, about how many days did you do other aerobic physical activities at least 30 minutes per day? (IF NONE, WRITE '0' ON THE LINE.)
   _____ Days

22. How many servings of fruit do you eat in a typical day? A serving includes: 1 medium fruit, 1/2 cup fresh, frozen, or canned fruit, 1/4 cup dried fruit, or 6 ounces fruit juice. (IF NONE, WRITE '0' ON THE LINE.)
   _____ Fruit servings per day

23. How many servings of vegetables do you eat in a typical day? A serving includes 1 cup raw leafy vegetables, 1/2 cup cooked or cut-up vegetable, or 6 ounces vegetable juice. (IF NONE, WRITE '0' ON THE LINE.)
   _____ Vegetable servings per day

24. During the last 30 days, about how many days did you drink any type of alcoholic beverage? (IF NONE, PLEASE WRITE '0' ON THE LINE.)
   _____ Days

25. If you drank any alcoholic beverage during the last 30 days, how many drinks did you usually have per day? (One drink equals one 5 oz. glass of wine, one 12 oz. can/bottle of beer, or one shot of whiskey/hard liquor.)
   ☐ None (never drank alcohol during last 30 days)
   ☐ 1 drink/shot
   ☐ 2 drinks/shots
   ☐ 3 drinks/shots
   ☐ 4 drinks/shots
   ☐ 5 drinks/shots
   ☐ 6 drinks/shots
   ☐ More than 6 drinks/shots

26. Do you currently smoke?
   ☐ Yes
   ☐ No

27. How tall are you without shoes? _____ feet _____ inches
28. How much do you weigh? _______ Pounds

29. Please check the number of times you have eaten the following foods in the past 2 days, not counting today.

a. In the last 2 days, how many times did you eat a salty snack (e.g. potato or corn chips, salted nuts or crackers, pretzels, cheese puffs)?
   1. Never
   2. 1-2 times
   3. 3-4 times
   4. 5-6 times
   5. 7 times or more

b. In the last 2 days, how many times did you add salt to your food at the table?
   1. Never
   2. 1-2 times
   3. 3-4 times
   4. 5-6 times
   5. 7 times or more

c. In the last 2 days, how many times did you eat fast food, pizza, or a frozen meal (other than low salt)?
   1. Never
   2. 1-2 times
   3. 3-4 times
   4. 5-6 times
   5. 7 times or more

d. In the last 2 days, how many times did you eat ham, bacon, hot dogs, sausage, or luncheon meat?
   1. Never
   2. 1-2 times
   3. 3-4 times
   4. 5-6 times
   5. 7 times or more

e. In the last 2 days, how many times did you eat canned vegetables or soup (other than low-salt)?
   1. Never
   2. 1-2 times
   3. 3-4 times
   4. 5-6 times
   5. 7 times or more
D. MEDICAL & PHARMACY SERVICES IN THE PAST 6 MONTHS

30. The next question asks about the number of times you received certain services in the past 6 months. For each service, enter how many times you received it. If you did not receive the service, please enter '0.'

In the past 6 months...

a. How many times were you admitted to a hospital? ................................................................. ____ times
b. How many times did you receive care at a hospital emergency room? ..................................... ____ times
c. How many times did you see a general doctor at their office or clinic? ..................................... ____ times
d. How many times did you see a medical specialist for a kidney, heart, or stroke problem? .......... ____ times
e. How many times did you pick up blood pressure medication at this pharmacy? ......................... ____ times
f. How many times did you talk with a pharmacist about your blood pressure or its treatment? .... ____ times
g. How many times did your pharmacist or pharmacy technician measure your blood pressure at this pharmacy? ........................................................................................................................ ____ times
h. How many times did your pharmacist or pharmacy technician call you at home for any reason? ____ times

31. Please check whether you received the following services from your pharmacist(s) in the past six months.

In the past 6 months, did your pharmacist(s) ...

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td></td>
</tr>
<tr>
<td>l.</td>
<td></td>
</tr>
<tr>
<td>m.</td>
<td></td>
</tr>
<tr>
<td>n.</td>
<td></td>
</tr>
</tbody>
</table>

32. Please rate the overall care you received from your pharmacist(s) in the past 6 months.

Very satisfactory Somewhat satisfactory Neither satisfactory nor unsatisfactory Somewhat unsatisfactory Very unsatisfactory

1  2  3  4  5

33. Please rate the overall care you received from the pharmacy assistants or technician(s) in the past 6 months.
E. YOUR HEALTH STATE TODAY

34. Please check which statement best describes your health state today. Check one box in each group.

a. Mobility
   1. I have no problems walking.
   2. I have some problems walking.
   3. I am confined to bed.

b. Self-care
   1. I have no problems with self-care.
   2. I have some problems washing or dressing myself.
   3. I am unable to wash or dress myself.

c. Usual activities (for example: work, study, housework, family or leisure activities)
   1. I have no problems with performing my usual activities.
   2. I have some problems with performing my usual activities.
   3. I am unable to perform my usual activities.

d. Pain/discomfort
   1. I have no pain or discomfort.
   2. I have moderate pain or discomfort.
   3. I have extreme pain or discomfort.

e. Anxiety/depression
   1. I am not anxious or depressed.
   2. I am moderately anxious or depressed.
   3. I am extremely anxious or depressed.

35. Below is a scale for helping people rate their health state. The worst state you can imagine is marked by 0. The best state you can imagine is marked by 100. CIRCLE one number that indicates how good or bad your own health state is today.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Worst imaginable health state</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Best imaginable health state</td>
</tr>
</tbody>
</table>
F. DEMOGRAPHIC INFORMATION

36. Are you male or female?
   ☐ Male
   ☐ Female

37. What is your birth date?
   Month: __________  Day: __________  Year: ___________

38. What is your race/ethnicity? (CHECK ALL THAT APPLY.)
   ☐ African American or Black
   ☐ American Indian or Alaskan Native
   ☐ Asian
   ☐ Hispanic or Latino/Latina
   ☐ Native Hawaiian/Other Pacific Islander
   ☐ White

39. What is the highest level of formal education you have received?
   ☐ Less than high school
   ☐ Some high school
   ☐ Completed high school or G.E.D.
   ☐ Some college or technical school
   ☐ Completed technical school/associate’s degree
   ☐ Completed B.A. or B.S. degree
   ☐ Graduate study/advanced degree(s)

40. What is your current employment status?
   ☐ Employed full-time (35 hours a week or more)
   ☐ Employed part-time (less than 35 hours a week)
   ☐ Not currently employed

41. How many adults and children live in your household, including yourself?
   ____ adults and children live in my household

42. What was your total household income in the past 12 months, from all sources? Please include income earned by you and other members of your household.
   ☐ Less than $10,000
   ☐ $10,000–$19,999
   ☐ $20,000–$29,999
   ☐ $30,000–$39,999
   ☐ $40,000–$49,999
   ☐ $50,000–$59,999
   ☐ $60,000–$69,999
   ☐ $70,000 or more

Thank you!
Please return this form to a researcher.