Your Name: _____

Patient Study ID # _____

Site # _____

Date _____

Interviewer ID # _____

Interviewer checked: □ Yes □ No

Patient Survey About High Blood Pressure and Its Treatment - 1

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!

Compiled for the TEAM (Team Education & Adherence Monitoring) Study
University of Wisconsin-Madison, School of Pharmacy

A. BACKGROUND INFORMATION

1. On average, how long does it take you to travel from your home to this pharmacy?

   1☐ Less than 10 minutes
   2☐ 10–19 minutes
   3☐ 20– 29 minutes
   4☐ 30 or more minutes

2. How do you **usually** get to this pharmacy?

   1☐ My own car
   2☐ Someone else's car
   3☐ Bus or train
   4☐ Taxi
   5☐ Walk or bicycle

3. Do you ever have to pay for transportation to get to this pharmacy?

   1☐ Yes
   2☐ 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?

   1☐ $2.00 or less
   2☐ $2.01–$5.00
   3☐ More than $5.00

5. How long have you been coming to this pharmacy for your blood pressure medication?

   1☐ Less than one year
   2☐ 1–2 years
   3☐ More than 2 years
   4☐ Don't remember

B. HEALTH HISTORY

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

	Yes	No		Yes	No
a. Diabetes or sugar diabetes?	1☐	2☐	i. Weak or failing kidneys?	1☐	2☐
b. A heart attack?	1☐	2☐	j. Kidney dialysis?	1☐	2☐
c. Congestive heart failure?	1☐	2☐	k. Narrowing of the arteries?	1☐	2☐
d. Enlarged heart?	1☐	2☐	l. Speech difficulty?	1☐	2☐
e. Angina (chest pain)?	1☐	2☐	m. Weakness on one side?	1☐	2☐
f. A coronary bypass?	1☐	2☐	n. Slurred speech?	1☐	2☐
g. A stroke?	1☐	2☐	o. Loss of balance?	1☐	2☐
h. High cholesterol?	1☐	2☐	p. Fainting or losing consciousness?	1☐	2☐

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

1☐ Yes
2☐ No
8☐ Don't know/Not applicable

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

1☐ Yes
2☐ No
8☐ Don't know/Not applicable

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

1☐ Yes
2☐ No
8☐ Don't know

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

	Yes	No		Yes	No
a. Dizziness	1☐	2☐	m. Numbness, tingling of hands	1☐	2☐
b. Headaches	1☐	2☐	n. Leg pain or swelling	1☐	2☐
c. Shortness of breath	1☐	2☐	o. Leg cramps	1☐	2☐
d. Feeling tired	1☐	2☐	p. Cold hands or feet	1☐	2☐
e. Thumping or racing heart	1☐	2☐	q. Difficulty breathing	1☐	2☐
f. Feeling weak when I stand up	1☐	2☐	r. Dry, hacking cough	1☐	2☐
g. Feeling depressed or blue	1☐	2☐	s. Decreased interest in sex	1☐	2☐
h. Frequent thirst	1☐	2☐	t. Unable to get an erection	1☐	2☐
i. Frequent urination	1☐	2☐	u. Difficulty sleeping	1☐	2☐
j. Dry mouth	1☐	2☐	v. Rash or hives	1☐	2☐
k. Loss of taste	1☐	2☐	w. Constipation or diarrhea	1☐	2☐
l. Blurry vision	1☐	2☐	x. Other → SPECIFY: _____	1☐	2☐

C. YOUR HIGH BLOOD PRESSURE & LIFESTYLE

11. How long have you been taking medication for high blood pressure?

1☐ Less than one year
2☐ 1–2 years
3☐ More than 2 years
8☐ Don't know

12. Has your doctor or health care provider ever told you what your **blood pressure GOAL should be**?

1☐ Yes, he/she told me my blood pressure numbers should be: ____/_____ or lower.
2☐ Yes, he/she gave me a blood pressure goal, but I do not remember the numbers.
3☐ No, he/she has never told me what my blood pressure numbers should be.
8☐ I don't remember.

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

1☐ I think my blood pressure numbers should be: ____/_____ or lower.
8☐ 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…

1☐ High
2☐ Borderline high
3☐ Normal/OK
4☐ Low
8☐ Don't know

15. How often can you tell by the way you feel that your blood pressure is too high?

1☐ Never
2☐ Rarely
3☐ Sometimes
4☐ Usually
5☐ Always

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

1☐ Very concerned
2☐ Somewhat concerned
3☐ A little concerned
4☐ 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.**

	I.. How hard do you think it would be for you to follow this guideline?	II. How helpful do you think it would be for you to follow this guideline?
a. Reduce the salt or sodium in your diet if needed	1☐ Very hard 2☐ Moderately hard 3☐ Not at all hard	1☐ Very helpful 2☐ Moderately helpful 3☐ Not at all helpful
b. Walk or exercise 30 minutes per day 5 days a week	1☐ Very hard 2☐ Moderately hard 3☐ Not at all hard	1☐ Very helpful 2☐ Moderately helpful 3☐ Not at all helpful
c. Eat 5 or more servings of vegetables and fruit a day	1☐ Very hard 2☐ Moderately hard 3☐ Not at all hard	1☐ Very helpful 2☐ Moderately helpful 3☐ Not at all helpful
d. Maintain normal weight or lose weight if needed	1☐ Very hard 2☐ Moderately hard 3☐ Not at all hard	1☐ Very helpful 2☐ Moderately helpful 3☐ Not at all helpful
e. Use alcohol in moderation (no more than 1-2 drinks per day)	1☐ Very hard 2☐ Moderately hard 3☐ Not at all hard	1☐ Very helpful 2☐ Moderately helpful 3☐ Not at all helpful
f. Take blood pressure medication every day	1☐ Very hard 2☐ Moderately hard 3☐ Not at all hard	1☐ Very helpful 2☐ Moderately helpful 3☐ Not at all helpful

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

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

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

	Yes	No
a. I use a blood pressure monitor to check my blood pressure at home	1☐	2☐
b. I use a special card to keep track of my blood pressure readings	1☐	2☐
c. I check food labels to help control or reduce the salt or sodium in my diet	1☐	2☐
d. I use a pedometer or step-counter to help stay active or monitor my walking	1☐	2☐

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, ½ cup fresh, frozen, or canned fruit, ¼ 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, ½ 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.)

0☐ None (never drank alcohol during last 30 days)
1☐ 1 drink/shot
2☐ 2 drinks/shots
3☐ 3 drinks/shots
4☐ 4 drinks/shots
5☐ 5 drinks/shots
6☐ 6 drinks/shots
7☐ More than 6 drinks/shots

26. Do you currently smoke?

1☐ Yes
2☐ 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 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) …	**Yes**	**No**
a. encourage you to keep track of your blood pressure numbers?	1☐	2☐
b. help you understand what your blood pressure numbers should be?	1☐	2☐
c. help you organize or remember your blood pressure medication?	1☐	2☐
d. help you reduce a medication side effect?	1☐	2☐
e. help you reduce medication costs?	1☐	2☐
f. encourage you to reduce the salt or sodium in your diet?	1☐	2☐
g. encourage you to take a daily walk or do physical exercise?	1☐	2☐
h. encourage you to eat more vegetables, fruit, & low-fat products?	1☐	2☐
i. suggest a change in blood pressure medication or dosage?	1☐	2☐
j. contact your doctor about your blood pressure?	1☐	2☐
k. ask how you are taking your blood pressure medication?	1☐	2☐
l. ask about your concerns and difficulties in taking blood pressure medication?	1☐	2☐
m. encourage you to take your blood pressure medication every day?	1☐	2☐
n. encourage you to set goals for improving your health?	1☐	2☐

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

1☐	2☐	3☐	4☐	5☐
Very satisfactory	Somewhat satisfactory	Neither satisfactory nor unsatisfactory	Somewhat unsatisfactory	Very unsatisfactory

33. Please rate the overall care you received from the **pharmacy assistants or technician(s)** in the past 6 months.

1☐	2☐	3☐	4☐	5☐
Very satisfactory	Somewhat satisfactory	Neither satisfactory nor unsatisfactory	Somewhat unsatisfactory	Very unsatisfactory

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.

0 **Worst imaginable health state**	10	20	30	40	50	60	70	80	90	100 **Best imaginable health state**

F. DEMOGRAPHIC INFORMATION

36. Are you male or female?

1☐ Male
2☐ Female

37. What is your birth date?

Month:_____ Day: _____ Year: _____

38. What is your race/ethnicity? (CHECK ALL THAT APPLY.)

1☐ African American or Black
2☐ American Indian or Alaskan Native
3☐ Asian
4☐ Hispanic or Latino/Latina
5☐ Native Hawaiian/Other Pacific Islander
6☐ White

39. What is the highest level of formal education you have received?

1☐ Less than high school
2☐ Some high school
3☐ Completed high school or G.E.D.
4☐ Some college or technical school
5☐ Completed technical school/associate's degree
6☐ Completed B.A. or B.S. degree
7☐ Graduate study/advanced degree(s)

40. What is your current employment status?

1☐ Employed full-time (35 hours a week or more)
2☐ Employed part-time (less than 35 hours a week)
3☐ 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.

1☐ Less than $10,000
2☐ $10,000–$19,999
3☐ $20,000–$29,999
4☐ $30,000–$39,999
5☐ $40,000–$49,999
6☐ $50,000–$59,999
7☐ $60,000–$69,999
8☐ $70,000 or more

Thank you!

Please return this form to a researcher.