Patient Name: _____ Patient Study ID # _____

Date _____

Interviewer ID # _____

Site # __ __

Interviewer checked for completeness:

☐ Yes

☐ No

Final Patient Survey - 3: 12 Month Follow-up

Thank you for participating in this follow-up survey. The questions ask about your health, blood pressure, and use of services in the past six months.

Thank you for your help!

Patient Survey 3

A. YOUR HEALTH AND LIFESTYLE IN THE PAST SIX MONTHS

1. Have you had any of the following problems <u>within the past six months</u>?

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

2. Have you had any of the following problems <u>within the past 30 days</u>?

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

3. Do you currently use the following methods for remembering your blood pressure medication? *Please check "yes" or "no" for each item.*

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

4. Do you currently use the following methods for monitoring your health and lifestyle?
Please check "yes" or "no" for each item.

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

5. Think about the time you spent <u>walking</u> 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.

<u>In the last 7 days,</u> about how many days did you walk at least 30 minutes per day? *(If none, write '0' on the line.)*

____ Days

6. Next, think about the time you spent doing <u>other aerobic physical activities</u> 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).

<u>In the last 7 days,</u> 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

7.* How many servings of fruit do you eat in a <u>typical day</u>? 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

***8.* How many servings of vegetables do you eat in a <u>typical day</u>? 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

***9.* <u>During the last 30 days</u>, about how many days did you drink any type of alcoholic beverage?** *(If none, please write '0' on the line.)*

____ Days

10. **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

11. Do you currently smoke?

- ❑ Yes
- ❑ No

12. How much do you currently weigh?

_____ **Pounds**

13. Please think about 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)?

- ❑ Never
- ❑ 1-2 times
- ❑ 3-4 times
- ❑ 5-6 times
- ❑ 7 times or more

b. In the last 2 days, how many times did you add salt to your food at the table?

- ❑ Never
- ❑ 1-2 times
- ❑ 3-4 times
- ❑ 5-6 times
- ❑ 7 times or more

c. In the last 2 days, how many times did you eat <u>fast food, pizza, or a frozen meal</u> (other than low salt)?

- ❑ Never
- ❑ 1-2 times
- ❑ 3-4 times
- ❑ 5-6 times
- ❑ 7 times or more

d. In the last 2 days, how many times did you eat <u>ham, bacon, hot dogs, sausage, or luncheon meat</u>?

- ❑ Never
- ❑ 1-2 times
- ❑ 3-4 times
- ❑ 5-6 times
- ❑ 7 times or more

e. In the last 2 days, how many times did you eat <u>canned vegetables or soup</u> (other than low-salt)?

- ❑ Never
- ❑ 1-2 times
- ❑ 3-4 times
- ❑ 5-6 times
- ❑ 7 times or more

14. Below is a scale for helping people rate their health state. The <u>worst state</u> you can imagine is marked by 0. The <u>best state</u> you can imagine is marked by 100. <u>CIRCLE</u> 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

B. MEDICAL & PHARMACY SERVICES IN THE PAST 6 MONTHS

15. The next question asks about <u>the number of times</u> 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 your 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 the pharmacy?	____ times
h. How many times did your pharmacist or pharmacy technician call you at home for any reason?	____ times

16. Do you know the name of your pharmacist?

- ❑ Yes
- ❑ No

17. Do you know the name of any pharmacy technicians at your pharmacy?

- ❑ Yes
- ❑ No

18. Please think about whether you received the following services from <u>your pharmacist(s)</u> in the past six months.

<u>In the past 6 months</u>, did your pharmacist(s) …	**Yes**	**No**
a. encourage you to keep track of your blood pressure numbers?.	❑	❑
b. help you understand what your blood pressure numbers should be?	❑	❑
c. help you organize or remember your blood pressure medication?	❑	❑
d. help you reduce a medication side effect?	❑	❑
e. help you reduce medication costs?	❑	❑
f. encourage you to reduce the salt or sodium in your diet?.	❑	❑
g. encourage you to take a daily walk or do physical exercise?	❑	❑
h. encourage you to eat more vegetables, fruit, & low-fat products?	❑	❑
i. suggest a change in blood pressure medication or dosage?	❑	❑
j. contact your doctor about your blood pressure?.	❑	❑
k. ask how you are taking your blood pressure medication?	❑	❑
l. ask about your concerns and difficulties in taking blood pressure medication?	❑	❑
m. encourage you to take your blood pressure medication every day?	❑	❑
n. encourage you to set goals for improving your health?	❑	❑

19. Please rate the overall care you received from your <u>pharmacist(s)</u> in the past 6 months.

Very satisfactory	**Somewhat satisfactory**	**Neither satisfactory nor unsatisfactory**	**Somewhat unsatisfactory**	**Very unsatisfactory**
❑	❑	❑	❑	❑

20. Please rate the overall care you received from the <u>pharmacy assistants or technician(s)</u> in the past 6 months.

Very satisfactory	**Somewhat satisfactory**	**Neither satisfactory nor unsatisfactory**	**Somewhat unsatisfactory**	**Very unsatisfactory**
❑	❑	❑	❑	❑

Thank you very much! Please return the survey to the interviewer.