

Patient Name: _____

Patient Study ID: _____

Site ID: ____ Interviewer ID: _____ Date: _____

Patient Screening Form 2 (PSF2)

A. Measurement of arm circumference

1. What is patient's arm circumference? _____ cm

(Interviewer: If arm is 31.9 cm or less, use regular cuff. If arm is 32.0 cm or more, use large cuff.)

B. Measurement of BP

2. SBP1 _____ DPB1 _____ Record but DO NOT use in determining average

3. SBP2 _____ DPB2 _____

4. SBP3 _____ DPB3 _____

5. Average SBP2 and SBP 3: _____

6. Average DBP2 and DBP 3: _____ Write lines 5-6 on BP card. Give card to patient.

C. Pharmacy Information

7. In the past six months, did you obtain any blood pressure medication from...

	Yes	No	If yes: where is the pharmacy or pharmacies located?
a. any Walgreen's pharmacies?	<input type="checkbox"/>	<input type="checkbox"/>	
b. any Aurora pharmacies?	<input type="checkbox"/>	<input type="checkbox"/>	
c. any other community, hospital, or mail-order pharmacies?	<input type="checkbox"/>	<input type="checkbox"/>	

8. In the past six months, did you obtain any free samples or supplies of prescription blood pressure medication ...

	Yes	No	If yes: what medication did you obtain?
a. at a doctor's office or clinic?	<input type="checkbox"/>	<input type="checkbox"/>	
b. at an emergency room or hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
c. from family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	

D. Insurance Data

It is important to learn more about the medications and services used by persons with high blood pressure. To do this, the researchers will need more information about any insurance you might have. These data will be kept confidential.

9. In the past six months, was there any change in your health insurance or coverage?

☐ Yes

9a. If **yes**, what changed? _____

☐ No

10. Do you currently have any health insurance that covers...	Yes	No
a. hospital?	<input type="checkbox"/>	<input type="checkbox"/>
b. medical or doctor visits?	<input type="checkbox"/>	<input type="checkbox"/>
c. prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>

11. Are you currently eligible for Medicaid or Medicaid managed care?

☐ Yes

If yes, may I see your card? a. Plan: _____

b. Member # _____

☐ No

12. Are you currently eligible for Medicare or Medicare managed care?

☐ Yes

If yes, may I see your card? a. Plan: _____

b. Member # _____

☐ No

13. Are you currently eligible for any other types of health insurance or benefits?

☐ Yes

If yes, may I see your card? a. Plan: _____

b. Member # _____

☐ No

14. (Interviewer: If Medicaid, Medicare, or other type:) The researchers may need your social security number to obtain the data needed for this study. Would you mind giving your social security number at this time?

SSN: _ _ _ - _ _ - _ _ _ _ _

☐ R refused