Patient Name: _____ Patient Study ID # _____

Date _____

Interviewer ID # _____

Site # __ __

Interviewer checked for completeness:

☐ Yes

☐ No

Patient Survey About High Blood Pressure - 2: 6 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!

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

A. YOUR HEALTH 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. Do you <u>now</u> take diabetic pills or insulin for diabetes?

- ❑ Yes
- ❑ No
- ❑ Don't know

3. 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: _____	❑	❑

B. YOUR BLOOD PRESSURE & LIFESTYLE

4. <u>In the past six months</u>, did you talk with a doctor about your high blood pressure?

1 ❑ Yes

2 ❑ No → ***SKIP TO QUESTION 6***

5. <u>In the past six months</u>, did your doctor tell you what your blood pressure GOAL should be?

❑ Yes, he/she told me my blood pressure numbers should be: ____/_____ or lower.

❑ 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 if he/she gave me a goal.

6. What do <u>you</u> think your blood pressure numbers should be?

❑ I think my blood pressure numbers should be: ____**/**____ or lower.

❑ I don't know what my blood pressure numbers should be.

7. What do you think about your blood pressure level <u>today</u>? Do you think it was…

❑ High

❑ Borderline high

❑ Normal / OK

❑ Low

❑ Don't know

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

❑ Never

❑ Rarely

❑ Sometimes

❑ Usually

❑ Always

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

❑ Very concerned

❑ Somewhat concerned

❑ A little concerned

4 ❑ Not at all concerned

10. Following are some medical guidelines for lowering blood pressure. Please check how <u>important</u> you think it is to follow each guideline.

a. Reduce the salt or sodium in your diet if needed	❑ Very important ❑ Moderately important ❑ Not at all important
b. Walk or exercise 30 minutes per day 5 days a week	❑ Very important ❑ Moderately important ❑ Not at all important
c. Eat 5 or more servings of vegetables and fruit a day	❑ Very important ❑ Moderately important ❑ Not at all important
d. Maintain normal weight or lose weight if needed	❑ Very important ❑ Moderately important ❑ Not at all important
e. Use alcohol in moderation (no more than 1-2 drinks per day)	❑ Very important ❑ Moderately important ❑ Not at all important
f. Take blood pressure medication every day	❑ Very important ❑ Moderately important ❑ Not at all important

11. 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: _____	❑	❑

12. 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	❑	❑

13. 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

14. 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

15.* 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

***16.* 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

***17.* <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

18. **If you drank any alcoholic beverage during the last 30 days, how many drinks did you usually have <u>per day</u>?** *(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

19. Do you currently smoke?

- ❑ Yes
- ❑ No

20. How tall are you without shoes?

_____**Feet** _____ **Inches**

21. How much do you weigh?

_____ **Pounds**

22. Please think about the number of times you have eaten the following foods <u>in the past 2 days</u>, not counting today.

a. In the last 2 days, how many times did you eat a <u>salty snack</u> (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 <u>add salt to your food</u> 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

C. MEDICAL & PHARMACY SERVICES IN THE PAST 6 MONTHS

23. 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

24. In the past six months, did you meet with a pharmacist to discuss your blood pressure?

- ❑ Yes
- ❑ No → ***SKIP TO QUESTION 26***

25. When visiting the pharmacy for your blood pressure discussions, how long did you usually have to wait for the pharmacist or technician to help you?

- ❑ Less than 5 minutes
- ❑ 5-10 minutes
- ❑ 10-15 minutes
- ❑ More than 15 minutes

26. 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?	❑	❑

27. 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**
❑	❑	❑	❑	❑

28. 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**
❑	❑	❑	❑	❑

D. YOUR HEALTH STATE TODAY

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

a. Mobility

- ❑ I have no problems walking.
- ❑ I have some problems walking.
- ❑ I am confined to bed.

b. Self-care

- ❑ I have no problems with self-care.
- ❑ I have some problems washing or dressing myself.
- ❑ I am unable to wash or dress myself.

c. Usual activities (for example: work, study, housework, family or leisure activities)

- ❑ I have no problems with performing my usual activities.
- ❑ I have some problems with performing my usual activities.
- ❑ I am unable to perform my usual activities.

d. Pain/discomfort

- ❑ I have no pain or discomfort.
- ❑ I have moderate pain or discomfort.
- ❑ I have extreme pain or discomfort.

e. Anxiety/depression

- ❑ I am not anxious or depressed.
- ❑ I am moderately anxious or depressed.
- ❑ I am extremely anxious or depressed.

30. 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

E. DEMOGRAPHIC INFORMATION

31. 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
- ❑ Retired

32. What is your marital status?

- ❑ Married
- ❑ Divorced or separated
- ❑ Single
- ❑ Widowed

***33.* How many children under 18 years old live in your household?** *(If NONE, write "0" on the line.)*

___ children live in my household

34. How many adults live in your household, including yourself?

___ adults live in my household (including yourself)

35. What was your total personal income in the past 12 months, from all sources? Do NOT include income earned by 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

36. If your pharmacy offered a program that included a free blood pressure check each month, might you be willing to participate?

❑ Definitely yes ❑ Probably yes ❑ Not sure ❑ Probably no ❑ Definitely no

37. Why do you feel this way? _____

_____

_____

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