Section 6. Blood Pressure Data Collection Form

Date: ________________ Name: _____________________________________
Screening number_______ Age________ Gender (Circle one) Female, Male
Name of Individual Conducting the Screening:______________________________

1) Have they ever been told by a doctor or other healthcare worker that they have raised blood pressure or hypertension? (Circle one) Yes, No

2) Are they currently receiving drugs for high blood pressure (that have been taken in the last 2 weeks) by a doctor or other health worker? (Circle one) Yes, No

Reading 1
Systolic (mmHg)____________
Diastolic (mmHg)____________

Reading 2
Systolic (mmHg)____________
Diastolic (mmHg)____________

Reading 3
Systolic (mmHg)____________
Diastolic (mmHg)____________

Average of readings 2 and 3
Systolic (mmHg)____________
Diastolic (mmHg)____________

Cuff size used (Circle one):  small, medium, large, thigh
Arm used for reading (Circle one):  Right, Left

3) Advice provided to person (Circle one): Yes No
Get Blood Pressure measured again in _______ (days/weeks/years)

See a Health Care professional in ___________ (days/weeks/years)

4) Any problems or medical history problems noted in screening (such as chest pain, shortness of breath, blurry vision, diabetes):

_______________________________________________________________

_______________________________________________________________

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People with high blood pressure readings who are being asked to see a healthcare professional should be provided with a copy of this data form to take with them. If the blood pressure readings vary by more than 10/5 mmHg consider taking more blood pressure readings. They should also be made aware of the risk for cardiovascular disease.

Consider adding the following optional questions to your data form (Circle either ‘Yes’ or ‘No’)

1) Is the person currently implementing any of the following treatments or advice for high blood pressure by a doctor or other health worker?
   a. advice to reduce alcohol consumption: Yes No
   b. advice to reduce salt intake: Yes No
   c. advice or treatment to lose weight: Yes No
   d. advice or treatment to stop smoking: Yes No
   e. advice to start or do more exercise: Yes No
   f. advice to consume healthier foods and beverages? Yes No

2) Is the person being assessed for or educated on Cardiovascular Disease? Yes No

1) Is the person being assessed for or educated on Type 2 Diabetes? Yes No

2) Does the person have a family history of Cardiovascular Disease? Yes No

3) Was the person’s Body Mass Index (BMI) measured? Yes No

If yes, please indicate the Height, Weight; BMI:

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\text{BMI} = \frac{\text{mass (kg)}}{\text{height (m)}^2} ; \text{BMI} = \frac{\text{mass (lb)}}{\text{height (in)}^2 \times 703.07}
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**BMI Categories (kg/m}^2\)**

Underweight = <18.5; Normal weight = 18.5–24.9; Overweight = 25–29.9; Obesity ≥ 30