

MMM22 DATA CAPTURE FORM

PLEASE COMPLETE IN BLOCK CAPITALS ONLY, IN BLACK INK AND INSERT ONLY X IN THE CHECKBOX FIELDS 



THE SCREENING SITE		*1a Name of Country:		*1b. Name of City/Town/Village:			
2		Site ID and / or investigator email address:					
3		Where is your screening site? <input type="checkbox"/> Hospital/Clinic/Pharmacy <input type="checkbox"/> Workplace <input type="checkbox"/> Public area (indoors) <input type="checkbox"/> Public area (outdoors) <input type="checkbox"/> Home <input type="checkbox"/> Other					
*4		Date of measurement	/...../.....			
BY COMPLETING THIS FORM YOU ARE CONSENTING TO SHARE YOUR INFORMATION FOR ACADEMIC RESEARCH PURPOSES. IF YOU DO NOT KNOW THE ANSWER LEAVE BLANK. DO NOT RECORD ANY PERSONAL DATA THAT WOULD IDENTIFY THE PATIENT E.G NAME, ADDRESS							
ABOUT THE PARTICIPANT		*5 How old are you in years? (Estimate if unknown)		Yrs <input type="checkbox"/> Mark with X if estimated			
		*6 What is your sex?		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			
		7 Ethnicity** (self-declared)		<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> South Asian <input type="checkbox"/> East/South East Asian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Mixed <input type="checkbox"/> Other			
		8 When did you last have your blood pressure (BP) measured?		<input type="checkbox"/> Never <input type="checkbox"/> Over 12 months ago <input type="checkbox"/> Within the last 12 months			
		9 Have you participated in MMM at least once before?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		*10 Have you ever been diagnosed with high BP by a health professional (except in pregnancy)?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		*10a If yes, at what age were you diagnosed?		Yrs			
		11 How many drug classes are you currently taking for your BP?***		<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+ <input type="checkbox"/> Don't know			
		12 Do you usually pay fees for your consultations when you get your BP treated?		<input type="checkbox"/> Pay nothing <input type="checkbox"/> Pay part <input type="checkbox"/> Pay fully <input type="checkbox"/> Not sure if part or fully paid			
		13 Do you usually pay fees for your medications when you get your BP treated?		<input type="checkbox"/> Pay nothing <input type="checkbox"/> Pay part <input type="checkbox"/> Pay fully <input type="checkbox"/> Not sure if part or fully paid			
		14 Do you take your BP medication regularly? If not - why? (Tick all that apply)		<input type="checkbox"/> I do <input type="checkbox"/> Too expensive <input type="checkbox"/> Not easily available <input type="checkbox"/> Side effects <input type="checkbox"/> Only take them when I need them <input type="checkbox"/> Prefer alternative medicine <input type="checkbox"/> I forget			
		15 Are you currently taking the following medications?		a) Statin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know c) Warfarin/oral anticoagulant (blood thinners) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		b) Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
		16 If female, are you pregnant?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		17 If female, have you had raised BP in this or a previous pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		18 If female, are you currently taking....		a) Hormonal contraception <input type="checkbox"/> Yes <input type="checkbox"/> No		b) Hormone replacement treatment (HRT) <input type="checkbox"/> Yes <input type="checkbox"/> No	
		19 Do you use tobacco? (including chewing tobacco, cigars and pipes)		<input type="checkbox"/> Yes <input type="checkbox"/> No – but I did in the past <input type="checkbox"/> Never			
		20 Do you consume alcohol?		<input type="checkbox"/> Never/rarely <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-6 times per week <input type="checkbox"/> Daily			
		21 Have you been diagnosed as having diabetes by a health professional (except in pregnancy)?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		22 Have you ever experienced or been diagnosed as having...		a) Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No c) Heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No		b) Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No d) Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	
		23 Have you had a positive test for COVID-19? If so, when?		<input type="checkbox"/> No Yes: <input type="checkbox"/> 0-3 mths ago <input type="checkbox"/> 3-6mths <input type="checkbox"/> 6-9mths <input type="checkbox"/> 9-12mths <input type="checkbox"/> >12 mths			
		23a If you answered YES to Q23, how long did your symptoms persist?		<input type="checkbox"/> 0-3 mths <input type="checkbox"/> 3-6mths <input type="checkbox"/> 6-9mths <input type="checkbox"/> 9-12mths <input type="checkbox"/> >12 mths			
24 Have you received the COVID-19 vaccination?		<input type="checkbox"/> No <input type="checkbox"/> Yes – 1 st <input type="checkbox"/> Yes – 1 st and 2 nd <input type="checkbox"/> Yes – 1 st , 2 nd , 3 rd					
25 Do you take part in at least 150 mins of moderate exercise (brisk walking) or 75 mins of more vigorous exercise per week?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
26 How many years of education do you have?		<input type="checkbox"/> 0 <input type="checkbox"/> 1-6 years <input type="checkbox"/> 7-12 years <input type="checkbox"/> over 12 years					
MEASUREMENTS		27 Weight (estimate if not measured)		Kilograms (kg) OR Pounds (lbs) <input type="checkbox"/> Mark with X if estimated			
		28 What was your birthweight?		Kilograms (kg) OR Pounds (lbs) <input type="checkbox"/> Don't know			
		29 What is the manufacturer of the BP machine being used?		<input type="checkbox"/> OMRON <input type="checkbox"/> Other			
		*30		Systolic Blood Pressure (SBP)		Diastolic Blood Pressure (DBP)	
				Pulse		Was the pulse regular?	
1 st measurement				<input type="checkbox"/> Yes <input type="checkbox"/> No			
2 nd measurement				<input type="checkbox"/> Yes <input type="checkbox"/> No			
3 rd measurement				<input type="checkbox"/> Yes <input type="checkbox"/> No			
IF YOUR COUNTRY IS TAKING PART IN THE ATRIAL FIBRILLATION SUB STUDY PLEASE COMPLETE THE QUESTIONS BELOW							
AF 31		Was Atrial Fibrillation detected in the current assessment?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
32		Have you ever been diagnosed as having Atrial Fibrillation by a health professional before?		<input type="checkbox"/> Yes <input type="checkbox"/> No			

*These questions must be answered in order to be submitted for May Measurement Month

** South Asian – with origins from: India, Pakistan, Bangladesh, Nepal, Bhutan, Maldives and Sri Lanka. East and South-East Asian – With Origins from any countries east of the Indian sub-continent.

*** This means how many types of medications are being taken i.e. – ACE-inhibitors, ARBs, diuretics, beta-blockers, calcium channel blockers, alpha-blockers, others. If you are unsure, please enter the number of different tablets each day. (If you are taking 1 tablet twice a day, this counts as 1).

† N/A = Not applicable