MMM24 DATA CAPTURE FORM

PLEASE COMPLETE IN BLOCK CAPITALS ONLY, IN BLACK INK AND INSERT ONLY X IN THE CHECKBOX FIELDS PLEASE ANSWER EVERY QUESTION ☒

SCREENING SITE	1a*	**Name of Country:**	**1b.* Name of City/Town/Village:**
	2*	**Site ID (country code and site number) :** _ _ _ / _ _ _	
	3	**Where is your screening site?**	☐ Hospital/Clinic ☐ Pharmacy ☐ Public area (indoors) ☐ Public area (outdoors) ☐ Home ☐ Workplace
	4*	**Date of measurement**	…DD…/…MM…/…YY…

BY COMPLETING THIS FORM YOU ARE CONSENTING TO SHARE YOUR INFORMATION FOR ACADEMIC RESEARCH PURPOSES. PLEASE ANSWER ALL QUESTIONS BUT IF YOU DO NOT KNOW THE ANSWER LEAVE BLANK. DO NOT RECORD ANY PERSONAL DATA E.G NAME, ADDRESS, PHONE NO.

ABOUT THE PARTICIPANT	5*	**How old are you in years? (Estimate if unknown)**	Yrs ☐ Mark with X if estimated
	6*	**What is your sex?**	☐ Male ☐ Female ☐ Other
	7*	**Ethnicity** (self-declared)**	☐ Black ☐ White ☐ South Asian ☐ East/South East Asian ☐ Middle Eastern ☐ Mixed ☐ Other
	8*	**When did you last have your blood pressure (BP) measured?**	☐ Never ☐ Over 12 months ago ☐ Within the last 12 months
	9*	**Have you ever been diagnosed with high BP by a health professional (except in pregnancy)?**	☐ Yes ☐ No
	10*	**Are you taking any BP medication?**	☐ Yes ☐ No
	10a*	**If you answered YES to Q10, how many different types of BP medication are you taking?*** **	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 + ☐ Don't know
	11	**Are you currently taking the following medications?**	**a)** Statin ☐ Yes ☐ No ☐ Don't know **b)** Aspirin ☐ Yes ☐ No ☐ Don't know **c)** Warfarin/oral anticoagulant (blood thinners) ☐ Yes ☐ No ☐ Don't know
	12*	**If female, are you pregnant?**	☐ Yes ☐ No
	13	**Do you use tobacco/nicotine? (including chewing tobacco, cigars, and pipes)**	☐ Yes ☐ No – but I did in the past ☐ Never
	14	**Do you vape (e-cigarettes)?**	☐ Yes ☐ No – but I did in the past ☐ Never
	15	**Do you consume alcohol?**	☐ Never/rarely ☐ 1-3 times per month ☐ 1-6 times per week ☐ Daily
	16*	**Have you ever experienced or been diagnosed as having…**	**a)** Heart attack ☐ Yes ☐ No **b)** Stroke ☐ Yes ☐ No **c)** Heart failure ☐ Yes ☐ No **d)** Irregular heartbeat ☐ Yes ☐ No **e)** Diabetes ☐ Yes ☐ No **f)** Kidney failure ☐ Yes ☐ No
	17	**Do you have a parent or sibling with diabetes?**	☐ Yes ☐ No ☐ Don't know
	18	**Do you take part in at least 150 mins of moderate exercise (brisk walking) or 75 mins of more vigorous exercise per week?**	☐ Yes ☐ No
	19	**What type of diet do you eat?**	☐ Omnivore**** ☐ Vegetarian ☐ Pescetarian (fish but no other meat) ☐ Vegan (no meat, fish or animal products)
	20	**How many years of education do you have?**	☐ 0 ☐ 1-6 years ☐ 7-12 years ☐ over 12 years

MEASUREMENTS	21*	**Weight (estimate if not measured)**	Kilograms (kg) **OR** Pounds (lbs)		☐ Mark with X if estimated
	22*	**Height**	Metres (m) **OR** Feet/Inches		☐ Mark with X if estimated
	23	**What is your waist size?**	Centimetres (cm) **OR** Inches		☐ Mark with X if estimated
	24	**What is the manufacturer of the BP machine being used?**	☐ OMRON ☐ Other		
	25*		**Systolic Blood Pressure (SBP)**	**Diastolic Blood Pressure (DBP)**	**Pulse**
		1st measurement			
		2nd measurement			
		3rd measurement			

*This is a mandatory question. Please ensure that all mandatory questions are answered.

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).

**** A person that eats a variety of food of both plant and animal origin.