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?	☐ Hospital/Clinic/Pharmacy ☐ Workplace ☐ Public area (indoors) ☐ Public area (outdoors) ☐ Home ☐ 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 ☐ 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 participated in MMM at least once before?	☐ Yes ☐ No
	*10	Have you ever been diagnosed with high BP by a health professional (except in pregnancy)?	☐ Yes ☐ No
	*10a	If yes, at what age were you diagnosed?	Yrs
	11	How many drug classes are you currently taking for your BP?***	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 + ☐ Don't know
	12	Do you usually pay fees for your consultations when you get your BP treated?	☐ Pay nothing ☐ Pay part ☐ Pay fully ☐ Not sure if part or fully paid
	13	Do you usually pay fees for your medications when you get your BP treated?	☐ Pay nothing ☐ Pay part ☐ Pay fully ☐ Not sure if part or fully paid
	14	Do you take your BP medication regularly? If not - why? (Tick all that apply)	☐ I do ☐ Too expensive ☐ Not easily available ☐ Side effects ☐ Only take them when I need them ☐ Prefer alternative medicine ☐ I forget
	15	Are you currently taking the following medications?	**a)** Statin ☐ Yes ☐ No ☐ Don't know **c)** Warfarin/oral anticoagulant (blood thinners) ☐ Yes ☐ No ☐ Don't know **b)** Aspirin ☐ Yes ☐ No ☐ Don't know
	16	If female, are you pregnant?	☐ Yes ☐ No
	17	If female, have you had raised BP in this or a previous pregnancy?	☐ Yes ☐ No
	18	If female, are you currently taking….	**a)** Hormonal contraception ☐ Yes ☐ No **b)** Hormone replacement treatment (HRT) ☐ Yes ☐ No
	19	Do you use tobacco? (including chewing tobacco, cigars and pipes)	☐ Yes ☐ No – but I did in the past ☐ Never
	20	Do you consume alcohol?	☐ Never/rarely ☐ 1-3 times per month ☐ 1-6 times per week ☐ Daily
	21	Have you been diagnosed as having diabetes by a health professional (except in pregnancy)?	☐ Yes ☐ No
	22	Have you ever experienced or been diagnosed as having…	**a)** Heart attack ☐ Yes ☐ No **c)** Heart failure ☐ Yes ☐ No **b)** Stroke ☐ Yes ☐ No **d)** Irregular heartbeat ☐ Yes ☐ No
	23	Have you had a positive test for COVID-19? If so, when?	☐ No Yes: ☐ 0-3 mths ago ☐ 3 – 6mths ☐ 6 – 9mths ☐ 9 – 12mths ☐ >12 mths
	23a	If you answered YES to Q23, how long did your symptoms persist?	☐ 0-3 mths ☐ 3 – 6mths ☐ 6 – 9mths ☐ 9 – 12mths ☐ >12 mths
	24	Have you received the COVID-19 vaccination?	☐ No ☐ Yes – 1st ☐ Yes – 1st and 2nd ☐ Yes – 1st, 2nd, 3rd
	25	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
	26	How many years of education do you have?	☐ 0 ☐ 1-6 years ☐ 7-12 years ☐ over 12 years
MEASUREMENTS	27	Weight (estimate if not measured)	Kilograms (kg) **OR** Pounds (lbs) ☐ Mark with X if estimated
	28	What was your birthweight?	Kilograms (kg) **OR** Pounds (lbs) ☐ Don't know
	29	What is the manufacturer of the BP machine being used?	☐ OMRON ☐ Other

		Systolic Blood Pressure (SBP)	Diastolic Blood Pressure (DBP)	Pulse	Was the pulse regular?
*30	1st measurement				☐ Yes ☐ No
	2nd measurement				☐ Yes ☐ No
	3rd measurement				☐ Yes ☐ 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?	☐ Yes ☐ No
	32	Have you ever been diagnosed as having Atrial Fibrillation by a health professional before?	☐ Yes ☐ 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).

Ŧ **N/A =** Not applicable