**SELF-CARE OF HIGH BLOOD PRESSURE**

**V2.0 (March 2016)**

*All answers are confidential.*

Think about how you have been feeling in the last month or since we last spoke as you complete these items.

**SECTION A:**

Listed below are common instructions given to persons with high blood pressure. How routinely do you do the following? Circle one number for each item.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Never or rarely** | Sometimes | Frequently | Always or daily |
| 1. Check your blood pressure? | 1 | 2 | 3 | 4 |
| 1. Eat lots of fruits and vegetables? | 1 | 2 | 3 | 4 |
| 1. Do some physical activity? | 1 | 2 | 3 | 4 |
| 1. Keep doctor or nurse appointments? | 1 | 2 | 3 | 4 |
| 1. Eat a low salt diet? | 1 | 2 | 3 | 4 |
| 1. Exercise for 30 minutes? | 1 | 2 | 3 | 4 |
| 1. Take medicines as prescribed? | 1 | 2 | 3 | 4 |
| 1. Ask for low salt items when eating out or visiting others? | 1 | 2 | 3 | 4 |
| 1. Use a system to help you remember your medicines? For example, use a pill box or reminders. | 1 | 2 | 3 | 4 |
| 1. Eat a low fat diet? | 1 | 2 | 3 | 4 |
| 1. Try to lose weight or control your body weight? | 1 | 2 | 3 | 4 |

**SECTION B:**

##### Many patients have difficulty controlling their blood pressure.

In the past month, has your blood pressure been high, even briefly? Circle one.

1. No
2. Yes

##### If you had trouble controlling your blood pressure in the past month…

(circle **one** number)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Have not had this** | **I did not** **recognize it** | **Not Quickly** | **Somewhat Quickly** | **Quickly** | **Very Quickly** |
| How *quickly* did you recognize that your blood pressure was up? | N/A | 0 | 1 | 2 | 3 | 4 |

Listed below are actions that people use to control their blood pressure. If your blood pressure goes up, how likely are you to try one of these actions?

(circle **one** number for each remedy)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not Likely** | **Somewhat Likely** | **Likely** | **Very Likely** |
| 1. Reduce the salt in your diet | 1 | 2 | 3 | 4 |
| 1. Reduce your stress level | 1 | 2 | 3 | 4 |
| 1. Be careful to take your prescription medicines more regularly | 1 | 2 | 3 | 4 |
| 1. Call your doctor/ nurse for guidance | 1 | 2 | 3 | 4 |

##### Think of an action you tried the last time your blood pressure was up,

(circle **one** number)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **I did not try anything** | **Not Sure** | **Somewhat Sure** | **Sure** | **Very Sure** |
| How sure were you that the action helped or did not help? | 0 | 1 | 2 | 3 | 4 |

**SECTION C**:

In general, how **confident** are you that you can:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not Confident** | **Somewhat Confident** | **Very Confident** | **Extremely Confident** |
| 1. Control your blood pressure? | 1 | 2 | 3 | 4 |
| 1. Follow your treatment regimen? | 1 | 2 | 3 | 4 |
| 1. Recognize changes in your health? | 1 | 2 | 3 | 4 |
| 1. Evaluate changes in your blood pressure? | 1 | 2 | 3 | 4 |
| 1. Take action that will control your blood pressure? | 1 | 2 | 3 | 4 |
| 1. Evaluate how well an action works? | 1 | 2 | 3 | 4 |