MMM26 DATA CAPTURE FORM

MAY MEASURE MONTH

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 CONSENT TO SHARE YOUR INFORMATION FOR ACADEMIC RESEARCH PURPOSES. PLEASE ANSWER ALL QUESTIONS. IF YOU DO NOT KNOW THE ANSWER, LEAVE IT BLANK. DO NOT PROVIDE ANY PERSONAL DATA SUCH AS NAME, ADDRESS, OR PHONE NUMBER

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/Southeast 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? (including chewing tobacco, cigarettes, 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	**How often do you drink high caffeine drinks?** (e.g. coffee, energy drinks e.g. Red Bull, Redline)	☐ Never or <4 per month ☐ 1-6 times per week ☐ 1-3 times per day ☐ 4+ per day
	17*	**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
	18	**Do you have a parent, brother or sister diagnosed with…**	**a)** High blood pressure ☐ Yes ☐ No ☐ Don't know **b)** Diabetes ☐ Yes ☐ No ☐ Don't know
	19	**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
	20	**Did you know that potassium-rich (or reduced/low sodium) salt can lower BP?**	☐ Yes ☐ No
	21	**How many years of education do you have?**	☐ 0 ☐ 1-6 yrs ☐ 7-12 yrs ☐ over 12 yrs
	22	**Do you use a BP monitor at home?**	☐ No ☐ Yes, an upper arm cuff monitor ☐ Yes, a wrist cuff monitor
	22a	**If YES to Q22, how often do you use this monitor?**	☐ <1 per month ☐ 1-3 times per month ☐ 1-6 times per week ☐ ≥ 1+ per day
MEASUREMENTS	23*	**Weight (estimate if not measured)**	Kilograms (kg) **OR** Pounds (lbs) ☐ Mark with X if estimated
	24*	**Height**	Metres (m) **OR** Feet/Inches ☐ Mark with X if estimated
	25	**What is your waist size?**	Centimetres (cm) **OR** Inches ☐ Mark with X if estimated
	26	**What is the manufacturer of the BP machine being used?**	☐ OMRON ☐ Other

27*		**Systolic Blood Pressure (SBP)**	**Diastolic Blood Pressure (DBP)**	**Pulse**
	1st measurement			
	2nd measurement			
	3rd measurement			

IF YOUR COUNTRY IS TAKING PART IN THE ATRIAL FIBRILLATION SUB STUDY PLEASE COMPLETE THE QUESTIONS BELOW

AF	28	**Was Atrial Fibrillation detected in the current assessment?**	☐ Yes ☐ No
	29	**Have you ever been diagnosed as having Atrial Fibrillation by a health professional before?**	☐ Yes ☐ No
	30	**Which device(s) was/were used to check whether AF was present?**	☐ None ☐ Omron Complete ☐Omron IntelliSense ☐ Omron M7

* 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).