

MMM26 DATA CAPTURE FORM

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? <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Public area (indoors) <input type="checkbox"/> Public area (outdoors) <input type="checkbox"/> Home <input type="checkbox"/> 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 <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/Southeast 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 ever been diagnosed with high BP by a health professional (except in pregnancy)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		10*		Are you taking any prescribed medications to lower your BP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
		10a*		If you answered YES to Q10, how many different types of BP medication are you taking?*** <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			
		11		Are you currently taking the following medications? a) Statin <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 c) Warfarin/oral anticoagulant (blood thinners) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
		12*		If female, are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
		13		Do you use tobacco? (including chewing tobacco, cigarettes, cigars, and pipes) <input type="checkbox"/> Yes <input type="checkbox"/> No – but I did in the past <input type="checkbox"/> Never			
		14		Do you vape (e-cigarettes)? <input type="checkbox"/> Yes <input type="checkbox"/> No – but I did in the past <input type="checkbox"/> Never			
		15		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			
		16		How often do you drink high caffeine drinks? (e.g. coffee, energy drinks e.g. Red Bull, Redline) <input type="checkbox"/> Never or <4 per month <input type="checkbox"/> 1-6 times per week <input type="checkbox"/> 1-3 times per day <input type="checkbox"/> 4+ per day			
		17*		Have you ever experienced or been diagnosed as having... a) Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know b) Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No c) Heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know d) Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No e) Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know f) Kidney failure <input type="checkbox"/> Yes <input type="checkbox"/> No			
		18		Do you have a parent, brother or sister diagnosed with... a) High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know b) Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		20		Did you know that potassium-rich (or reduced/low sodium) salt can lower BP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		21		How many years of education do you have? <input type="checkbox"/> 0 <input type="checkbox"/> 1-6 yrs <input type="checkbox"/> 7-12 yrs <input type="checkbox"/> over 12 yrs			
		22		Do you use a BP monitor at home? <input type="checkbox"/> No <input type="checkbox"/> Yes, an upper arm cuff monitor <input type="checkbox"/> Yes, a wrist cuff monitor			
22a		If YES to Q22, how often do you use this monitor?**** <input type="checkbox"/> <1 per month <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-6 times per week <input type="checkbox"/> ≥ 1+ per day					
MEASUREMENTS		23*		Weight (estimate if not measured) Kilograms (kg) OR Pounds (lbs) <input type="checkbox"/> Mark if estimated <input type="checkbox"/> Don't know			
		24*		Height (estimate if not measured) Metres (m) OR Feet/Inches <input type="checkbox"/> Mark if estimated <input type="checkbox"/> Don't know			
		25		Waist size (estimate if not measured) Centimetres (cm) OR Inches <input type="checkbox"/> Mark if estimated <input type="checkbox"/> Don't know			
		26		What is the manufacturer of the BP machine being used? <input type="checkbox"/> OMRON <input type="checkbox"/> Other			
		27*		Systolic Blood Pressure (SBP)		Diastolic Blood Pressure (DBP)	
		1 st measurement					
		2 nd measurement					
		3 rd 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		29		Have you ever been diagnosed as having Atrial Fibrillation by a health professional before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		30		Which device(s) was/were used to check whether AF was present? <input type="checkbox"/> None <input type="checkbox"/> Omron Complete <input type="checkbox"/> Omron IntelliSense <input type="checkbox"/> 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).
***This refers to the total number of home BP measurement sessions, not the number of BP readings taken.