

NAME/ID:

DATE:

Current Weight: _____ kg lbs

Date checked: _____ n/a

Height: _____ feet/inches cm

*Body Mass Index (BMI): _____ *To be calculated by clinician

Blood Pressure: _____/_____ mmHg

Date checked: _____ n/a

Fasting Glucose: _____ mmol/L mg/dl

Date checked: _____ n/a

HbA1c: _____ %

Date checked: _____ n/a

We are interested in your own beliefs about your health. We are NOT interested in what others believe or may wish you to believe.

Indicate if you have any of the following health related experiences by reading the questions and marking either Yes or No.

	Yes	No
A) Do you regularly feel nervous?	<input type="checkbox"/>	<input type="checkbox"/>
B) Do you regularly sweat?	<input type="checkbox"/>	<input type="checkbox"/>
C) Do you regularly have difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
D) Do you regularly have facial flushing? Do your cheeks get red?	<input type="checkbox"/>	<input type="checkbox"/>
E) Do you regularly have shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
F) Do you regularly have headaches?	<input type="checkbox"/>	<input type="checkbox"/>
G) Do you regularly have nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>
H) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

If 'NO' to ALL of the above, please go to the next page.

If 'YES' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your health related experiences.

1) My health related experiences are due to having high blood pressure.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Strongly Disagree

Moderately Disagree

Slightly Disagree

Unsure

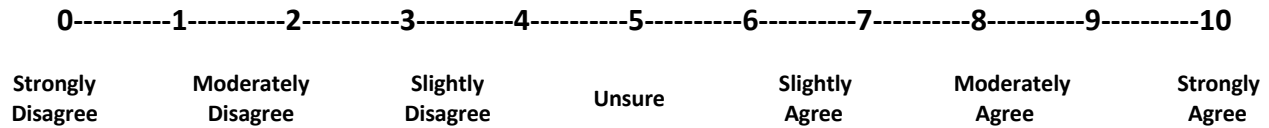
Slightly Agree

Moderately Agree

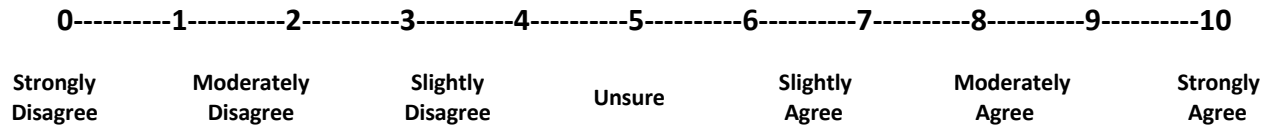
Strongly Agree

Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

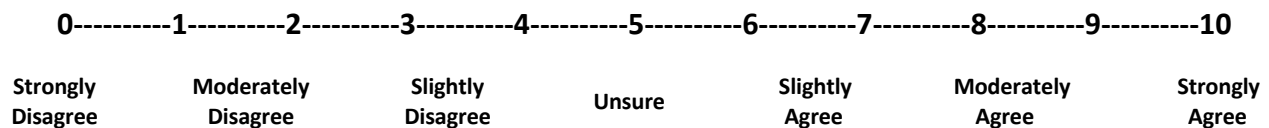
2) I have hypertension (i.e. high blood pressure).



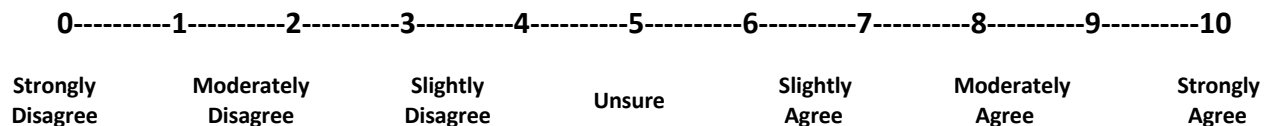
3) I NEED to make or maintain healthy life style changes to improve my diet and/or adjust the amount I exercise.



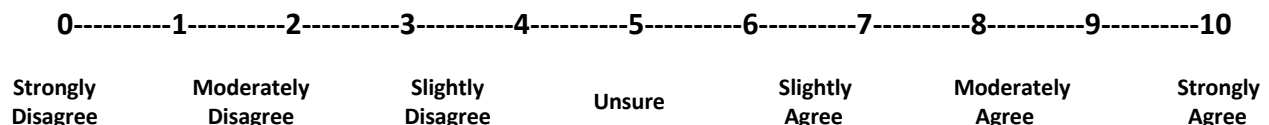
4) I have a normal blood pressure.*



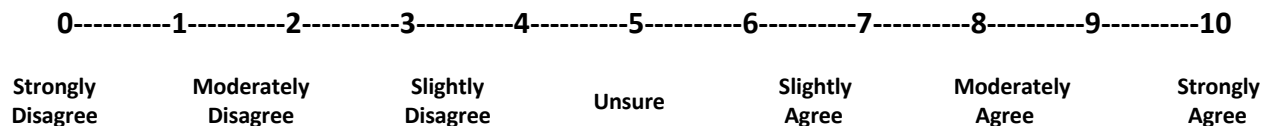
5) I can safely carry on my current lifestyle (i.e. eating/drinking and exercising as I currently do).*



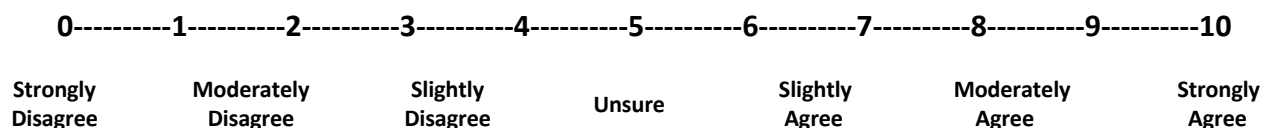
6) My high blood pressure has led or can lead to negative health consequences (e.g. heart disease, heart attack, heart failure, stroke, near stroke, kidney/renal disease, vision loss, etc.).



7) My blood pressure is regularly in the hypertensive range (i.e. $\geq 140/90$).*



8) I need blood pressure lowering medication.



THE END

*See scoring sheet for applicability