


| <p align="center"><b>HYPERTENSION PAGE<br/>(SAMPLE PERSONS ONLY)</b></p>   | <p align="center">Person number<br/>_____</p> | <p align="center"><b>HPI</b></p> | <p>1 <input type="checkbox"/> SP under 17 (Medical Care Page)<br/> 2 <input type="checkbox"/> Eligible resp. avail. (1)<br/> 3 <input type="checkbox"/> Return call required (Next Hypertension Page)</p>                      |
|--|---|----------------------------------|--|
| <p>1a. Have you EVER been told by a doctor that you had high blood pressure?</p>   |   |                                  | <p>1 Y (7c) _____ 2 N _____</p>  |
| <p>b. Another name for high blood pressure is hypertension. Have you EVER been told by a doctor that you had hypertension?</p>                 |   |                                  | <p>1 Y _____ 2 N (10) _____</p>  |
| <p>c. About how long ago were you FIRST told by a doctor that you had (high blood pressure/hypertension)?</p>                                  |   |                                  | <p>000 <input type="checkbox"/> Less than 1 month<br/> 1 _____ Months<br/> 2 _____ Years</p>   |
| <p>2. During the past 12 months about how many times have you seen or talked to a doctor about your (high blood pressure/hypertension)?</p>    |   |                                  | <p>_____ Times<br/> 000 <input type="checkbox"/> None</p>  |
| <p>3. Has a doctor EVER advised you to lose weight BECAUSE OF (HIGH BLOOD PRESSURE/HYPERTENSION)?</p>  |   |                                  | <p>1 Y _____ 2 N _____</p>   |
| <p>4a. Do you now use more salt, less salt, or about the same amount of salt since you learned you had (high blood pressure/hypertension)?</p> |   |                                  | <p>1 <input type="checkbox"/> More<br/> 2 <input type="checkbox"/> Less<br/> 3 <input type="checkbox"/> Same</p>   |
| <p>d. Were you EVER advised by a doctor, nurse, or other medical person to use less salt?</p>  |   |                                  | <p>1 Y _____ 2 N _____</p>   |
| <p>5a. Has a doctor EVER prescribed medicine for your (high blood pressure/hypertension)?</p>  |   |                                  | <p>1 Y _____ 2 N (6) _____</p>   |
| <p>b. Are you now taking any medicine prescribed by a doctor for your (high blood pressure/hypertension)?</p>                                  |   |                                  | <p>1 Y _____ 2 N (5f) _____</p>  |
| <p>c. How often are you supposed to take this medicine – more than once a day, once a day, or less than once a day?</p>                        |   |                                  | <p>1 <input type="checkbox"/> More than once a day<br/> 2 <input type="checkbox"/> Once a day<br/> 3 <input type="checkbox"/> Less than once a day</p>   |
| <p>d. How often do you take your medicine when you are supposed to – all the time, often, once in a while, or never?</p>                       |   |                                  | <p>1 <input type="checkbox"/> All the time<br/> 2 <input type="checkbox"/> Often<br/> 3 <input type="checkbox"/> Once in a while<br/> 0 <input type="checkbox"/> Never<br/> <input type="checkbox"/> Other (Specify) _____</p> |
| <p>e. Does your medicine ever cause any side effects or make you feel funny in any way?</p>  |   |                                  | <p>1 Y (6) _____ 2 N (6) _____</p>   |
| <p>f. Why did you stop taking the medicine? Any other reason?</p>  |   |                                  | <p>1 <input type="checkbox"/> Doctor's advice (5h)<br/> 2 <input type="checkbox"/> No longer has high blood pressure<br/> 3 <input type="checkbox"/> Side effects<br/> <input type="checkbox"/> Other (Specify) _____</p>      |
| <p>Mark all that apply </p>                                |   |                                  |  |
| <p>g. Did a doctor advise you to stop taking the medicine?</p>   |   |                                  | <p>1 Y _____ 2 N _____</p>   |
| <p>If "Side effects" in 5f, go to 6; otherwise ask:</p>  |   |                                  |  |
| <p>h. When you were taking this medicine did it cause any side effects or make you feel funny in any way?</p>                                  |   |                                  | <p>1 Y _____ 2 N _____</p>   |

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| <p>6. ABOUT how many days during the past 12 months has (high blood pressure/hypertension) kept you in bed all or most of the day?</p>   | <p>_____ Days<br/>000 <input type="checkbox"/> None</p>   |
| <p>If "No longer has high blood pressure" in 5f, go to 7d, otherwise ask.</p> <p>7a. How often does your (high blood pressure/hypertension) bother you – all the time, often, once in a while, or never?</p>                 | <p>1 <input type="checkbox"/> All the time<br/>2 <input type="checkbox"/> Often<br/>3 <input type="checkbox"/> Once in a while<br/>0 <input type="checkbox"/> Never (7c)<br/><input type="checkbox"/> Other (Specify) <u>7</u></p>                                      |
| <p>b. When it does bother you, are you bothered a great deal, some, or very little?</p>  | <p>1 <input type="checkbox"/> Great deal<br/>2 <input type="checkbox"/> Some<br/>3 <input type="checkbox"/> Very little<br/><input type="checkbox"/> Other (Specify) <u>7</u></p>   |
| <p>If "All the time" in 7a, go to 8, otherwise ask:</p> <p>c. Do you still have (high blood pressure/hypertension)?</p>  | <p>1 Y (8)      2 N      9 DK</p>   |
| <p>d. Is this condition completely cured or is it under control?</p>   | <p>1 <input type="checkbox"/> Cured (10)<br/>2 <input type="checkbox"/> Under control</p>   |
| <p>8. Can you tell when your blood pressure is high – that is, do you have any symptoms?</p>   | <p>1 Y      2 N</p>   |
| <p>9. Have you ever been refused life insurance or health insurance coverage because you had (high blood pressure/hypertension)?</p>   | <p>1 Y      2 N</p>   |
| <p>10a. Has a doctor EVER talked to you about problems that can be caused by high blood pressure or hypertension?</p>  | <p>1 Y (HP2)      2 N</p>   |
| <p>b. Has a nurse or other medical person EVER talked to you about problems that can be caused by high blood pressure or hypertension?</p>   | <p>1 Y      2 N (HP2)</p>   |
| <p>c. What type of medical person was this?</p>  | <p>1 <input type="checkbox"/> Nurse<br/><input type="checkbox"/> Other (Specify) <u>7</u></p>   |
| <p><b>HP2</b> <input type="checkbox"/> No 2-week DV in CI (11)<br/><input type="checkbox"/> 2-week DV in CI } Refer to THIS PERSON'S doctor visit columns.<br/>If "Y" in 7a in ANY column, go to 14, otherwise go to 11.</p> |   |
| <p>11. ABOUT how long has it been since you LAST had your blood pressure taken?</p>  | <p>999 <input type="checkbox"/> Never (16)<br/>000 <input type="checkbox"/> Less than 1 month<br/>1 _____ Months<br/>2 _____ Years (16)</p>   |
| <p>12. Who took your blood pressure the LAST time?</p>   | <p>1 <input type="checkbox"/> Doctor<br/>2 <input type="checkbox"/> Nurse<br/>3 <input type="checkbox"/> Friend or relative<br/>4 <input type="checkbox"/> Druggist<br/>5 <input type="checkbox"/> Self (13b)<br/><input type="checkbox"/> Other (Specify) <u>7</u></p> |

|   |  |
|---|--|
| <p>13a. Were you told that your reading was high, low, normal, or were you not told?</p> <p>-----</p> <p>b. Was your reading high, low, or normal?</p>  | <p>1 <input type="checkbox"/> High<br/> 2 <input type="checkbox"/> Low<br/> 3 <input type="checkbox"/> Normal<br/> 4 <input type="checkbox"/> Not told<br/> <input type="checkbox"/> Other (Specify) _____ } (14)</p> <p>1 <input type="checkbox"/> High<br/> 2 <input type="checkbox"/> Low<br/> 3 <input type="checkbox"/> Normal<br/> <input type="checkbox"/> Other (Specify) _____ } (15)</p> |
| <p>14. During the past 12 months, have you taken your own blood pressure?</p>   | <p>1 Y                      2 N</p>  |
| <p>15. During the past 12 months, how many times was your blood pressure taken? (Do not count times while a patient in a hospital.)</p>   | <p>_____ Times</p>   |
| <p>16a. ABOUT how long has it been since you had an electrocardiogram, which involves placing wires on the chest and arms?</p> <p>-----</p> <p>b. ABOUT how long has it been since you had a chest X-ray?</p> | <p>98 <input type="checkbox"/> Never<br/> 00 <input type="checkbox"/> Less than 1 year<br/> _____ Years</p> <p>98 <input type="checkbox"/> Never<br/> 00 <input type="checkbox"/> Less than 1 year<br/> _____ Years</p>  |
| <p>17a. ABOUT how much do you weigh?</p> <p>-----</p>   | <p>_____ Pounds</p>  |
| <p>b. ABOUT how tall are you?</p>   | <p>_____ Feet      _____ Inches</p>  |
| <p>c. Do you consider yourself overweight, underweight, or just about right?</p> <p>-----</p>   | <p>1 <input type="checkbox"/> Overweight<br/> 2 <input type="checkbox"/> Underweight (17)<br/> 3 <input type="checkbox"/> About right (17a)</p>  |
| <p>d. Are you now trying to lose weight?</p> <p>-----</p>   | <p>1 Y (17f)                      2 N</p>  |
| <p>e. Are you now trying to keep from gaining weight?</p> <p>-----</p>  | <p>1 Y                              2 N (18)</p>   |
| <p>f. Is this based on advice from a doctor, nurse, or other medical person?</p> <p>-----</p>   | <p>1 Y                              2 N</p>  |
| <p>g. What are you doing to (lose/control your) weight – watching what you eat, exercising, or something else? Anything else?</p> <p>-----</p>  | <p>1 <input type="checkbox"/> Diet<br/> 2 <input type="checkbox"/> Exercise<br/> 3 <input type="checkbox"/> Medication<br/> <input type="checkbox"/> Other (Specify) _____ }<br/> _____</p> <p>Mark all that apply</p>   |

|   |                  |                         |
|---|------------------|-------------------------|
| 18. Have you EVER been told by a doctor that you had diabetes?      | 1 Y              | 2 N                     |
| 19. Have you EVER been told by a doctor that you had heart trouble? | 1 Y              | 2 N                     |
| 20. Have you EVER had a stroke?                                     | 1 Y              | 2 N                     |
| 21a. Have you smoked at least 100 cigarettes in your entire life?   | 1 Y              | 2 N (Medical Care Page) |
| -----   |                  |                         |
| b. Do you smoke cigarettes now?                                     | 1 Y              | 2 N (21e)               |
| -----   |                  |                         |
| c. On the average, ABOUT how many cigarettes a day do you smoke?    | ----- Cigarettes |                         |
| -----   |                  |                         |
| d. Have you EVER tried to stop smoking?                             | 1 Y              | 2 N                     |
| -----   |                  |                         |
| e. Have you EVER been advised by a doctor to stop smoking?          | 1 Y              | 2 N (Medical Care Page) |
| -----   |                  |                         |
| f. Was this because of a specific condition you had at that time?   | 1 Y              | 2 N (Medical Care Page) |
| -----   |                  |                         |
| g. What condition was it?   | -----<br>-----   |                         |
| -----   |                  |                         |
| h. Any other condition?   | Y (Reask 21g)    | N                       |
| FOOTNOTES   |                  |                         |
|   |                  |                         |