**Participant HBPM Experience Form**

**We will record the start date and expected end date. Please record your actual start date and end date and return with the home blood pressure monitor (HBPM) device.**

You will start the morning of : \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_ [MM/DD/YYYY]

We expect you to finish the evening of : \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_[MM/DD/YYYY]

**Record your Actual Start Date & Time of Day:** \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_ □AM or □PM

MM DD YYYY

**Record your Actual End Date & Time of Day:** \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_ □AM or □PM

MM DD YYYY

**Was the Omron blood pressure monitor used by anyone else other than you?**

* Yes
* No

**Compared to a typical week, please rate whether you had more or less of the following things during your 8 days of blood pressure monitoring (check 1 box for each item):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Much less** | **A little less** | **About the Same** | **A little more** | **Much more** |
| **A.** Stress | □ | □ | □ | □ | □ |
| **B.** Pain | □ | □ | □ | □ | □ |
| **C.** Time sleeping | □ | □ | □ | □ | □ |
| **D.** Physical activity | □ | □ | □ | □ | □ |
| **E.** Feeling light-headed or dizzy | □ | □ | □ | □ | □ |
| **F.** Number of headaches | □ | □ | □ | □ | □ |
| **G.** Time feeling sick | □ | □ | □ | □ | □ |
| **H.** Prescribed medications | □ | □ | □ | □ | □ |

**When complete, please return this form with your home blood pressure device.**

**Thank you for your continued participation in ARIC!**