

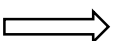


## High Blood Pressure Survey

1. How well do you feel that your blood pressure is controlled?
  1. Uncontrolled
  2. Somewhat uncontrolled
  3. Neutral
  4. Somewhat controlled
  5. Controlled
  
2. Please indicate how often you take your blood pressure between office visits:
  1. Never
  2. Once or twice
  3. Once a month
  4. Once a week
  5. Everyday
  
3. Please circle any of the following that could be effects of high blood pressure:
  - a. Kidney damage
  - b. Eye damage
  - c. Brain damage
  - d. Blood vessel damage
  - e. Heart failure
  - f. Stroke
  
4. Which of the following measurements lowers blood pressure the most?
  - a. Weight Reduction
  - b. DASH Diet
  - c. Dietary Sodium Reduction
  - d. Physical Activity
  - e. Lowering Alcohol Consumption
  - f. unsure
  
5. What is your target blood pressure?

X: unsure

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6. Do you think you have adequate knowledge to manage your high blood pressure?
  1. Not at all
  - 2.- Maybe
  - 3.- Yes
  
7. Do you think you would benefit from additional support to manage your blood pressure?
  1. - Not at all
  - 2.- Very little
  - 3.- Somewhat
  - 4.- Moderately
  - 5.- Definitely
  
8. How willing are you to come into the office for blood pressure checks?
  - 1 - Not at all
  - 2- Somewhat
  - 3- Willing
  - 4- Very willing
  - 5- Extremely willing
  
9. Which of the following options would you find helpful in controlling your blood pressure? (Select all that apply)
  - a. My Health Online portal with helpful tips and reminders about blood pressure control
  - b. Regular 15-30 minute office visits with highly trained nursing staff to develop a plan for lowering blood pressure
  - c. Annual physician visits with about 5 minutes devoted to blood pressure counseling
  
10. Do you feel that it is important to see the same provider (nurse or physician) for each blood pressure visit?
  - a. Yes
  - b. No

*Thank you!*