



22510

**PATIENT-PHYSICIAN PARTNERSHIP TO  
IMPROVE HBP ADHERENCE  
3 MONTH PATIENT QUESTIONNAIRE**

Date (mm/dd/yyyy)

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Pt Study # (PID)

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**This questionnaire asks for your views about health and how well you are able to do your usual activities. Please circle your responses to each question.**

1. In general would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**The following items are about activities you might do during a typical day.**

**Does your health now limit you in these activities? If so, how much?**

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all
3. Climbing several flights of stairs. ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

4. Accomplished less than you would like? ☐ Yes ☐ No
5. Were limited in the kind of work or other activities? ☐ Yes ☐ No

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

6. Accomplished less than you would like? ☐ Yes ☐ No
7. Didn't do work or other activities as carefully as usual? ☐ Yes ☐ No



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8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ☐ Not at all   ☐ a little bit   ☐ Moderately   ☐ Quite a bit   ☐ Extremely

**These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

**How much of the time during the past 4 weeks:**

9. Have you felt calm and peaceful?

- ☐ All of the time   ☐ Most of the time   ☐ A good bit of the time   ☐ Some of the time   ☐ A little of the time   ☐ None of the time

10. Did you have a lot of energy?

- ☐ All of the time   ☐ Most of the time   ☐ A good bit of the time   ☐ Some of the time   ☐ A little of the time   ☐ None of the time

11. Have you felt downhearted and blue?

- ☐ All of the time   ☐ Most of the time   ☐ A good bit of the time   ☐ Some of the time   ☐ A little of the time   ☐ None of the time

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ A little of the time   ☐ None of the time

**Now, we would like to know some other general information about you.**

13. What role would you like to play when seeing your doctor? (Read all 4 statements)

- ☐ The doctor takes the initiative and decides what is best for me  
☐ The doctor considers some of my ideas but still makes most, if not all of the final decisions  
☐ The doctor and I make the final decisions together  
☐ I make all the final decisions



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14. In the past 3 months, have you done anything differently to take care of your blood pressure?

- |                         |                           |                          |                           |
|-------------------------|---------------------------|--------------------------|---------------------------|
| a. change your diet?    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| b. lose weight?         | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| c. cut back on salt?    | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| d. exercise more?       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| e. cut back on alcohol? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |
| f. quit smoking?        | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> N/A |

**People often have difficulty taking their pills for one reason or another. We are interested in finding out any problems that occur so we can better understand them. These questions will help us to understand those reasons.**

**(For HBP, say high blood pressure)**

15. Are you following the HBP treatment recommended by the doctor?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

16. Are you keeping track of your blood pressure level to see if it is under control?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

17. Are you taking care of problems that get in the way of controlling your HBP?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

18. How often do you forget to take your HBP medicine?

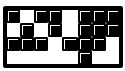
- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

19. How often do you decide NOT to take your HBP medicine?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

20. How often do you eat salty food?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know



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21. How often do you shake salt on your food before you eat it?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

22. How often do you eat fast food?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

23. How often do you make the next appointment before you leave the doctor's office?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

24. How often do you miss scheduled appointments?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

25. How often do you forget to get prescriptions filled?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

26. Did your doctor prescribe HBP medicine for you within the last 6 months?

- ☐ Yes   ☐ No

27. Did you get this prescription filled?

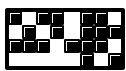
- ☐ Yes   ☐ No

28. How often do you run out of HBP pills?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

29. How often do you skip your HBP medicine before you go to the doctor?

- ☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know



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30. How often do you skip your medicine when you are drinking alcohol?

☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

31. How often do you miss taking your HBP pills when you feel better?

☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

32. How often do you miss your HBP pills when you feel sick?

☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

33. How often do you miss taking your HBP pills because you are careless?

☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

34. How often do you miss taking your HBP pills because of financial concerns (cost, co-payment)?

☐ All of the time   ☐ Most of the time   ☐ Some of the time   ☐ None of the time   ☐ N/A   ☐ Don't know

35. In the next 3 months, how confident are you that you will start or continue doing the following things?

a. change your diet?   ☐ Not at all   ☐ Somewhat   ☐ Completely   ☐ N/A

b. lose weight?   ☐ Not at all   ☐ Somewhat   ☐ Completely   ☐ N/A

c. cut back on salt?   ☐ Not at all   ☐ Somewhat   ☐ Completely   ☐ N/A

d. exercise more?   ☐ Not at all   ☐ Somewhat   ☐ Completely   ☐ N/A

e. cut back on alcohol?   ☐ Not at all   ☐ Somewhat   ☐ Completely   ☐ N/A

f. quit smoking?   ☐ Not at all   ☐ Somewhat   ☐ Completely   ☐ N/A

Pt Study # (PID)

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Please look at the label or container for each medication to answer the next few questions. Skip to question 46 after going through the list of hypertension medications that you have been taking.

## 36. Medication #1

a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--	--

b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

d. During the past 3 months, how many months did you take this medication?

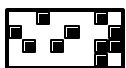
- ☐ Less than one month
- ☐ one month
- ☐ two months
- ☐ three months

e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes   ☐ no

f. Where did you last have this medication refilled?

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## 37. Medication #2

a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

d. During the past 3 months, how many months did you take this medication?

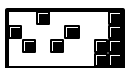
- ☐ Less than one month
- ☐ one month
- ☐ two months
- ☐ three months

e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes ☐ no

f. Where did you last have this medication refilled?

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## 38. Medication #3

a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

d. During the past 3 months, how many months did you take this medication?

- ☐ Less than one month
- ☐ one month
- ☐ two months
- ☐ three months

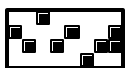
e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes ☐ no

f. Where did you last have this medication refilled?

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## 39. Medication #4

- a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME:

--	--	--	--	--	--	--	--	--	--

- b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

- c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

- d. During the past 3 months, how many months did you take this medication?

- ☐ Less than one month  
☐ one month  
☐ two months  
☐ three months

- e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes    ☐ no

- f. Where did you last have this medication refilled?

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## 40. Medication #5

a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

d. During the past 3 months, how many months did you take this medication?

- ☐ Less than one month
- ☐ one month
- ☐ two months
- ☐ three months

e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes    ☐ no

f. Where did you last have this medication refilled?

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## 41. Medication #6

- a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

- b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

- c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number /Day

- d. During the past 3 months, how many months did you take this medication?

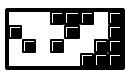
- ☐ Less than one month  
☐ one month  
☐ two months  
☐ three months

- e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes ☐ no

- f. Where did you last have this medication refilled?

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## 42. Medication #7

- a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

- b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

- c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

- d. During the past 3 months, how many months did you take this medication?

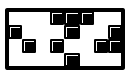
- ☐ Less than one month  
☐ one month  
☐ two months  
☐ three months

- e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes ☐ no

- f. Where did you last have this medication refilled?

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## 43. Medication #8

- a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

- b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

- c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

- d. During the past 3 months, how many months did you take this medication?

- ☐ Less than one month  
☐ one month  
☐ two months  
☐ three months

- e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes    ☐ no

- f. Where did you last have this medication refilled?

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## 44. Medication #9

- a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

- b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

- c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

- d. During the past 3 months, how many months did you take this medication?

- ☐ Less than one month  
☐ one month  
☐ two months  
☐ three months

- e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes ☐ no

- f. Where did you last have this medication refilled?

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## 45. Medication #10

a. what is the name of this medication? (INTERVIEWER: CHECK MEDICATION LIST FOR CODE. IF DRUG IS NOT ON LIST, WRITE IN THE NAME OF THE DRUG AND LEAVE THE CODE BLANK)

DRUG NAME :

--	--	--	--	--	--	--	--	--	--

b. During the past 30 days, on how many days did you actually take this medication?

--	--

 Days

c. How many pills (capsules or other measures of this medication) do you usually take each day?

--	--

 Number / Day

d. During the past 3 months, how many months did you take this medication?

- ☐ Less than one month
- ☐ one month
- ☐ two months
- ☐ three months

e. In the past 3 months, did you stop taking any of these medications on your own without the doctor telling you to do that?

☐ yes ☐ no

f. Where did you last have this medication refilled?

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Now I would like to ask you some questions about visits you have made to doctors and other health care professionals.

46. During the past 6 months, how many total nights have you stayed in a hospital or other treatment facility for treatment of physical problems?

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 Nights

47. Have you ever been an overnight patient in a hospital for any emotional or personal problems?

- ☐ Yes, in the past 6 months
- ☐ Yes, but not in the past 6 months (go to question #49)
- ☐ No (go to question #49)

48. During the past 6 months, how many total nights did you stay in a hospital or other treatment facility for any personal or emotional problems? Please count all overnight stays?

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 Nights

49. During the past 6 months, how many visits did you make to a hospital emergency room?

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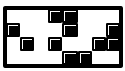
 Visits

50. During the past 6 months, how many visits did you make to medical providers such as primary care or family doctors, internists, surgeons or medical specialists, physician's assistants or medical nurse practitioners? This question refers to office or clinic visits. Please do not include visits to a hospital emergency room, overnight stays in a hospital, nursing home, or other health care facility.

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 Visits





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51. How dissatisfied or satisfied were you with the overall health care available to you during the past 6 months - very dissatisfied, dissatisfied, neither dissatisfied nor satisfied, satisfied, or very satisfied?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither dissatisfied nor satisfied
- ☐ Satisfied
- ☐ Very satisfied
- ☐ Don't know

Do Not Duplicate