

## HUNT 2 Questionnaire 3

Supplementary form on **hypertension**

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By completing this questionnaire, you will help us to improve the treatment of high blood pressure. Please read the brochure 'hunt-special' that you received at the health examination.

Good luck!

### DIAGNOSIS

**When were you first told that you had high blood pressure?** Year \_\_\_\_

**When were you first prescribed medicine for high blood pressure?** Year \_\_\_\_

**Have you ever been examined at hospital because of your blood pressure?** <Yes, No, Don't know>

If YES, **when were you last at hospital?** Year \_\_\_\_

### MEDICAL EXAMINATIONS AND MEASUREMENTS

**When you go for an examination, who usually measures your blood pressure?**

Doctor

Medical secretary or nurse

Think about the last 12 months:

**How many times have you been to the doctor to have your blood pressure measured?** Put 0 if you have not been to have it measured Times \_\_\_\_

**How many times have you been to a medical secretary or nurse to have your blood pressure measured (without seeing the doctor)?** No. of times \_\_\_\_

**Do you think your blood pressure examinations have been too often, suitably often or not often enough?** *One X only*

Too often

Suitably often

Not often enough

**When your blood pressure was last measured (not including at this health study), were you told what blood pressure values were measured?** <Yes, No, Don't remember>

**Have you ever measured your blood pressure yourself at home?** <yes, no>

**Do you have a blood pressure monitor at home?** <yes, no>

## MEDICINES

**Are you currently taking medicine for high blood pressure?** <yes, no>

If NO, go to ADVICE

**What medicine(s) are you taking for your blood pressure?**

Write the name of the medicine (see the box/bottle), the strength of the tablets and the number of tablets per day

Name of the medicine	Strength of each tablet	Number of tablets per day
	mg	
	mg	
	mg	

**Have you had changes in your medication in the last 12 months?** One X on each line <yes, no>

I started new medication(s)

I stopped taking a/some medication(s)

I increased the dose of one or more of my medications

I reduced the dose of one or more of my medications

If YES to one or more of the previous questions, answer the following questions.

**Why was your medicine changed?** One or more Xs

My blood pressure was too high

My blood pressure was too low

I had discomfort/side effects from the medicine(s)

I don't know, the doctor made the decision

Other reasons

**Do you use a tablet dispenser?** <yes, no>

**Have you ever experienced discomfort/side effects from the medicines?** <Yes, No, Not sure>

If NO, go to ADVICE

**Have you experienced discomfort/side effects from the medicines in the last week?** <Yes, No, Not sure>

If YES, **what kind of discomfort/side effects did you experience in the last week?** Write on the lines below

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**How troublesome was the discomfort/were the side effects in the last week?** *One X only*

Very troublesome

Quite troublesome

Somewhat troublesome

Not troublesome

**How important do you think the blood pressure medicine actually is for you?** *One X only*

Not so important

Somewhat important

Important

Very important

#### ADVICE

**Has the doctor given you any advice regarding your high blood pressure?**

(Put an X in only one box) <Yes, No, Don't remember>

If NO, go to POSSIBLE DISADVANTAGES

If YES, **what was the advice?** One X on each line <yes, no>

Lose weight

Smoke less or preferably quit smoking

Exercise more

Eat less sugar and fat

Use less salt in food

Live a calmer life (less stress)

Other \_\_\_\_\_

**How important do you think the advice the doctor gave you are** (in addition to the medicine)? *One*

*X only*

Not so important

Somewhat important

Important

Very important

#### POSSIBLE DISADVANTAGES

**What do you think is the greatest disadvantage associated with your blood pressure?** *One X only*

*only*

Having to go for medical examinations

Having to take medicine

Having to smoke less/quit

Having to eat "correctly"/lose weight

Being regarded as a patient with something wrong with me

There are no disadvantages

Other \_\_\_\_\_

**Do you think that your blood pressure, as it has been in the last years, has been so high that it could lead to health problems?** *One X only*

Yes, certainly

Yes, perhaps

No

Don't know

If YES, **how much does it worry you?** *One X only*

Very little

A little

Much

Very much

THE HEALTH STUDY IN 1984-86

**Did you take part in the previous Health Study in Nord-Trøndelag in 1984-86?** <Yes, No, Don't remember>

If YES, **were you called in for an extra examination to the doctor after that health survey?** <Yes, No, Don't remember >

IF YOU NO LONGER TAKE MEDICINE FOR YOUR BLOOD PRESSURE

**When did you stop taking medicine?** Year \_\_\_\_\_

**Why did you stop taking medicine?**

Doctor's orders

I experienced side effects from the medicine

I didn't think that the medicine was necessary

I was afraid the medicine was bad for me

Other reason (write the reason below)

\_\_\_\_\_

OTHER SUGGESTIONS

**Do you have any suggestions for how blood pressure treatment can be improved?**

**Please put this questionnaire in the same envelope as the other questionnaires that you were given at the health examination and post them as soon as possible.**

**The postage is paid.**

**Many thanks for your help!**