

SV2
 ID number _____
 Candidate's initials _____
 Visit date ____/____/____

**TRIALS OF HYPERTENSION PREVENTION
 VISIT CHECKLIST—SCREENING VISIT #2**

- | 1. Indicate candidate's eligibility status for each of the following items: | ELIGIBLE
(1) | INELIGIBLE
(2) |
|---|--------------------------|--------------------------|
| a) Blood pressure (sum of 6 readings 459–567 mm Hg) | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Medical history (items 11–12) | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Use of benzodiazepines, hydroxyzines or meprobamates | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Use in past 2 months of exclusionary drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Multiple vitamin use | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Individual supplements use | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Use of antacids | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Use of over the counter diuretics | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Other | <input type="checkbox"/> | <input type="checkbox"/> |
| (Specify _____) | | <input type="checkbox"/> |

IF CANDIDATE IS INELIGIBLE FOR ANY REASON, GO TO ITEM 10.

- | | | |
|---|----------------------------------|---------------------------------|
| 2. IF ELIGIBLE, IS candidate <u>WILLING</u> to schedule next visit? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |
| IF NO: Reason _____ | | |

- | | |
|---|--|
| 3. Date of scheduled Screening Visit #3 | _____ / _____ / _____ |
| | month day year |

REMINDER: SV3 MUST BE SCHEDULED 10–30 DAYS AFTER SV2.

- | | | |
|---|----------------------------------|---------------------------------|
| 4. Has candidate completed Physical Activity Questionnaire? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |
| 5. Has candidate completed Hassles Scale? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |
| 6. Has candidate completed Well Being Scale? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |
| 7. Has candidate completed Health Locus of Control? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |
| 8. Has candidate been given a 24-hour urine kit? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |
| 9. Has candidate been given a food frequency questionnaire
to complete for the next appointment? | YES <input type="checkbox"/> (1) | NO <input type="checkbox"/> (2) |

10. TOHP identification number of person responsible for
 completing this form

11. TOHP identification number of person responsible for
 editing this form

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**TRIALS OF HYPERTENSION PREVENTION
 SCREENING FORM #2**

1. Date of SV1 month / day / year
2. Is this visit at least 10 and no more than 30 days after SV1 (item #1)? YES (1) NO (2)
3. PREPARATION FOR BLOOD PRESSURE MEASUREMENTS
 - a. Arm circumference cm
 - b. Time of day AM / PM
 WAIT FIVE MINUTES
 - c. Time of day AM / PM
 - d. Room temperature °F
 - e. Cuff size Small adult (<24 cm) (1)
 Large adult (33-41 cm) (3)
 - f. Resting 30-second pulse /30 seconds
 - g. Pulse obliteration pressure mm Hg
 + 3 0
 - h. Maximum zero mm Hg
 - i. Random zero peak inflation level mm Hg
 - j. TOHP certification number of random zero device
4. First random zero blood pressure

SBP/DBP

 - a. Reading / mm Hg
 - b. Zero value
 - c. Corrected value (a - b) mm Hg
 WAIT 30 SECONDS
5. Second random zero blood pressure

SBP/DBP

 - a. Reading / mm Hg
 - b. Zero value
 - c. Corrected value (a - b) mm Hg
 WAIT 30 SECONDS
6. Third random zero blood pressure

SBP/DBP

 - a. Reading / mm Hg
 - b. Zero value
 - c. Corrected value (a - b) mm Hg
7. Sum of 3 DBPs, items 4c + 5c + 6c
8. Sum of 3 DBPs from SV1 (item #9)
9. Sum of 6 DBPs, items 7 + 8
 IF THIS SUM IS OUTSIDE THE RANGE 459-567 mm Hg, the candidate
 is INELIGIBLE. TERMINATE THE INTERVIEW.
10. TOHP identification number of person taking BP

SV2

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Visit date ____/____/____

**STAFF
REVIEW**

11. Hospitalization within past five years YES (1)
 IF YES: Specify reason(s) _____ NO (2)
 Reason for exclusion? YES, CVD (1)
 YES, Other (2)
 NO (3)
12. Surgery within past five years YES (1)
 IF YES: Specify reason(s) _____ NO (2)
 Reason for exclusion? YES, CVD (1)
 YES, Other (2)
 NO (3)
13. Daily use of benzodiazepines, hydroxyzines, or meprobamates YES* (1)
 NO (2)
14. Prescription drugs used currently or within past 2 months:
 a. _____ NONE
 b. _____
 c. _____
 d. _____
 e. _____
-
15. Current use of multivitamin supplement YES (1) NO (2)
 IF YES: Does it include calcium, magnesium or potassium? YES (1) NO (2)
 IF YES: Willing to discontinue it? YES (1) NO* (2)
16. Current use of any of the following individual nutritional supplements:
 a. Calcium YES (1) NO (2)
 b. Fish oil (omega-3 fatty acids) YES (1) NO (2)
 c. Magnesium YES (1) NO (2)
 d. Potassium YES (1) NO (2)
 IF YES TO ANY OF 16a-d: Willing to discontinue them? YES (1) NO* (2)
17. Current use of antacids at least once per week, on average YES (1) NO (2)
 IF YES: Willing to discontinue them? YES (1) NO* (2)
18. Current regular use of non-prescription diuretics YES (1) NO (2)
 IF YES: Willing to discontinue them? YES (1) NO* (2)