**Attachment 1f**

**National Health and Nutrition Examination Survey (NHANES)**

**Ambulatory Blood Pressure Monitoring (ABPM) Feasibility Study**

**Study Diary**

Form Approved

OMB no. 0920-0950

Expires: 12/31/2017

**Assurance of confidentiality –** All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

Public reporting burden of this collection of information is estimated to average 24hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333. ATTN: PRA (0920-0950).

This attachment represents the 24 hour period during which participants will be wearing the Ambulatory Blood Pressure Monitoring device (ABPM). It also captures the study diary (see below) that participants will fill out while they are wearing the ABPM device.

**Study Diary Questionnaire**

**AMBULATORY BP DIARY SP ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. At what time was the device placed on your arm? \_\_\_\_\_\_\_  *(completed by technician)*
2. At what time was it removed? \_\_\_\_\_\_\_\_\_*( completed by technician or person)*
3. At what time did you eat:
* Lunch \_\_\_\_\_\_\_\_\_\_\_Dinner \_\_\_\_\_\_\_\_\_\_\_Breakfast\_\_\_\_\_\_\_\_
* Snacks\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_
1. Do you take medication?
* If so, fill in the table below with the name(s) of your medication(s), the dosage(s), and at what time(s) did you take your medicine?
* Was this different in any way from how you usually take your medication? If yes, how?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Name** | **Dosage** | **Time taken** | **Is this for High Blood Pressure?** |
| 1 |  |  |                         am/pm | Yes/No |
| 2 |  |  |                         am/pm | Yes/No |
| 3 |  |  |                         am/pm | Yes/No |
| 4 |  |  |                         am/pm | Yes/No |
| 5 |  |  | am/pm | Yes/No |
| 6 |  |  | am/pm | Yes/No |
| 7 |  |  | am/pm | Yes/No |
| 8 |  |  | am/pm | Yes/No |
| 9 |  |  | am/pm | Yes/No |
| 10 |  |  | am/pm | Yes/No |

1. Did you exercise or do anything strenuous (such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate), during the time you were wearing the device? \_\_\_\_\_\_ (yes/no)
* If so, what type of strenuous activity was it, at what time(s) did you engage in the activity, and for how long did you do the activity (duration in hours (h) or minutes (m))?

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity** | **Activity Type** | **Time** | **Duration** |
| 1 |  |                        am/pm |                               h/m |
| 2 |  |                        am/pm |                               h/m |
| 3 |  |                        am/pm |                               h/m |
| 4 |  |                        am/pm |                               h/m |
| 5 |  |                        am/pm |                               h/m |

1. What time did you go to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What time did you wake up the next morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Did you have to remove your device during the testing period?
	1. If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when? \_\_\_\_     (am/pm)
	2. If yes, for how long? \_\_\_\_ (hours/minutes)

c. Did you put the device back on? Yes or No

1. Did you find it difficult to put it back on correctly? Yes or No
* If so, what part of the placement was the most difficult? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 10. During the time you wore the blood pressure device, did you spend any time at work (in paid

 employment)? If yes, when did work begin? \_\_\_\_\_ am/pm. When did work end? \_\_\_\_\_\_ am/pm

 11. Is there anything else you’d like to tell us about your experience using the ABPM?