

## 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

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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 \_\_\_\_\_

- 4. 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

- 5. 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

- 6. What time did you go to sleep? \_\_\_\_\_
- 7. What time did you wake up the next morning? \_\_\_\_\_
- 8. Did you have to remove your device during the testing period?
  - a. If yes, why? \_\_\_\_\_ when? \_\_\_\_\_ (am/pm)
  - b. If yes, for how long? \_\_\_\_\_ (hours/minutes)
  - c. Did you put the device back on? Yes or No

9. 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?