

# NOT FOR DISTRIBUTION FOR REVIEW PURPOSES ONLY

## SURVEY FOR PATIENTS WITH HIGH BLOOD PRESSURE

High blood pressure is one of the most important health problems in the United States. You can help our office give you the best possible care for your high blood pressure by completing this survey.

We hope you will answer the questions. No one here will know how you answered the questions. And if you choose to not answer, that's okay.

The survey is easy to do. It will take less than ten minutes. You can do it by using the phone or over the Internet.



### USE A TOUCH-TONE PHONE

You may want to read the questions and pick your answers before you call.

- Call the toll-free telephone number: **1-800-841-6024**
- Enter the identification number for *Physician's Name Here*  
*Physician's ID Number Here*
- Answer the questions using the telephone key pad. You can have someone help you.



### USE THE INTERNET

- Go to [www.abim.org/survey](http://www.abim.org/survey)
- Select English or Spanish
- Enter the identification number for *Physician's Name Here*  
*Physician's ID Number Here*
- Click on the "Begin Survey" button
- Read the questions and select your answers
- When you finish, click on the "Submit Survey" button

Thank you very much.

1. **How would you rate your overall health?**
  - 1 Excellent
  - 2 Very good
  - 3 Good
  - 4 Fair
  - 5 Poor
2. **How would you describe your current level of fitness?**
  - 1 Really in shape
  - 2 In shape
  - 3 So-so
  - 4 Out of shape
  - 5 Really out of shape
3. **Has your doctor or someone in the practice advised you to exercise regularly?**
  - 1 Yes, more than once
  - 2 Yes, once
  - 3 No
  - 4 I'm not sure
  - 5 Not applicable
4. **During a typical week, how many days do you get a total of at least 30 minutes of physical activity that raises your heart rate?**
5. **Please enter the number of servings of fruits and vegetables you eat in a typical day.**
6. **How often do you (or whoever buys your groceries) read the Nutrition Facts label on food items to decide whether or not to buy them?**
  - 1 Most of the time
  - 2 Some of the time
  - 3 Almost never
  - 4 I'm not sure
7. **How is this practice at giving you information about foods to eat and foods to avoid?**
  - 1 Excellent
  - 2 Very good
  - 3 Good
  - 4 Fair
  - 5 Poor
8. **How often do you follow your recommended eating plan?**
  - 1 Always
  - 2 Usually
  - 3 Sometimes
  - 4 Never
  - 5 Not Applicable (I don't have a recommended eating plan)
9. **Do you smoke cigarettes?**
  - 1 Yes
  - 2 No
10. **If you smoke, has your doctor advised you to stop?**
  - 1 Yes, more than once
  - 2 Yes, once
  - 3 No
  - 4 I'm not sure
  - 5 Not applicable
11. **Has your doctor or someone in the doctor's office taken your blood pressure within the past year?**
  - 1 Yes, and it was fine
  - 2 Yes, and it was too high
  - 3 Yes, but I don't know what it was
  - 4 No, it hasn't been taken within the past year
  - 5 I'm not sure
12. **Do you check your blood pressure at home?**
  - 1 Yes, regularly
  - 2 Yes, once in a while
  - 3 No
13. **If you check your blood pressure at home, does your doctor or someone in the practice ask you about the results you get at home?**
  - 1 Yes, at most visits
  - 2 Yes, occasionally
  - 3 No, I haven't been asked about the results
  - 4 I'm not sure
  - 5 Not Applicable (I don't check my blood pressure at home)

14. **Has your cholesterol been tested within the past five years?**
- 1 Yes, and it was fine
  - 2 Yes, and it needed improvement
  - 3 Yes, but I don't know what it was
  - 4 No, it hasn't been tested
  - 5 I'm not sure
15. **Has your urine been tested for protein?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
16. **Has your doctor or someone in the practice given you information about the effects of high blood pressure on the kidneys?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
17. **How is this practice at encouraging you to ask questions and answering them clearly?**
- 1 Excellent
  - 2 Very Good
  - 3 Good
  - 4 Fair
  - 5 Poor
18. **Overall, how would you rate this practice at taking care of your blood pressure?**
- 1 Excellent
  - 2 Very Good
  - 3 Good
  - 4 Fair
  - 5 Poor
19. **Would you recommend this practice to family or friends with high blood pressure?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
20. **How is this practice at making sure you have the information you need to take your medications properly?**
- 1 Excellent
  - 2 Very good
  - 3 Good
  - 4 Fair
  - 5 Poor
  - 6 Not applicable
21. **Has your doctor or someone in the practice asked you about side effects of your medications?**
- 1 Yes, more than once
  - 2 Yes, once
  - 3 No
  - 4 I'm not sure
  - 5 Not applicable
22. **How is this practice at giving you the information you need about the side effects of your medications?**
- 1 Excellent
  - 2 Very Good
  - 3 Good
  - 4 Fair
  - 5 Poor
  - 6 Not applicable
23. **Many people find it difficult to take all of their doses of blood pressure medication. During the past week, how many doses of your blood pressure medications did you miss?**
- 1 I haven't missed any medication doses.
  - 2 I have missed one or two doses.
  - 3 I have missed three or four doses.
  - 4 I have missed five or more doses.
  - 5 Not applicable. (I don't take blood pressure medicine.)
24. **IN THE PAST 12 MONTHS, how much of a problem has it been to schedule appointments with this practice?**
- 1 Not a problem
  - 2 A small problem
  - 3 A big problem
  - 4 Not applicable



- 25. IN THE PAST 12 MONTHS, how much of a problem has it been to reach this practice when you have a question or concern?**
- 1 Not a problem
  - 2 A small problem
  - 3 A big problem
  - 4 Not applicable
- 26. IN THE PAST 12 MONTHS, how much of a problem has it been to get a prescription refill from this practice?**
- 1 Not a problem
  - 2 A small problem
  - 3 A big problem
  - 4 Not applicable
- 27. IN THE PAST 12 MONTHS, how much of a problem has it been to get a referral from this practice?**
- 1 Not a problem
  - 2 A small problem
  - 3 A big problem
  - 4 Not applicable
- 28. IN THE PAST 12 MONTHS, how much of a problem has it been to get your laboratory test results from this practice?**
- 1 Not a problem
  - 2 A small problem
  - 3 A big problem
  - 4 Not applicable
- 29. Have you ever had a heart attack?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
- 30. Have you ever had a stroke?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
- 31. Did either of your parents or any siblings have a heart attack or stroke when they were younger than 65?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
- 32. Have you ever been told by a doctor that you have diabetes?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
- 33. Do you have kidney disease or protein in your urine?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
- 34. Do you have leg muscle tightness or fatigue when you walk or climb a flight of stairs?**
- 1 Yes
  - 2 No
  - 3 I'm not sure
- 35. Please enter the two-digit number that represents your age.**
- 36. Please enter your gender.**
- 1 Male
  - 2 Female

Thank you for taking the time to complete this survey.

This survey is part of a program sponsored by the American Board of Internal Medicine.