Client Survey Questionnaire

Section 1: Demographic Characteristics

Questions	Responses	Code
Name of the respondent	…….	
Enter the ID of the respondent	…….	
Name of the health facility from where contact information was obtained	…….	
Select the type of health facility	Pharmacy Health Post Urban Health Center Sishuwa Hospital	1 2 3 4
Age of the respondent	☐☐ (Completed years)	
Gender of the respondent	Male Female Others	1 2 96
Address of the respondent	…… Ward Number	
Tole name	…… Tole	
Marital status of the respondent	Married Divorced Separated Widowed Never- Married	0 1 2 3 4
What is your occupation? That is, what kind of work does you mainly do? (Source: NDHS, 2022)	Services Unskilled Manual Skilled Manual Professional/ technical/ managerial	0 1 2 3

	Agriculture Home maker Unemployed Other (Specify)…….	4 5 6 96
What is the main source of income for your family? (Source: NDHS, 2022)	Daily wage labor Skilled labor Government Non-government Petty business Business Farmer (Agriculture/ Animal husbandry) Pension Self- employed Foreign employment Other (Specify)…….	0 1 2 3 4 5 6 7 8 9 96

Section 2: Care seeking behavior

Questions	Options	Code
Do you have health insurance?	Yes No	1 0
Currently, what health problems do you have? (Select multiple if needed)	Hypertension Diabetes Mellitus None Other (Specify)……	0 1 2 96
Do you currently take medication for hypertension?	Yes No	1 0
If no, why not?	Side effect of medicines Cost of medicines Fear of being habitual Lack of trust towards health provider Need to consume lifelong Control via lifestyle modification Other (Specify)…….	0 1 2 3 4 5 96
Where were you diagnosed with hypertension?		

	…… (Name/ Type of facility)	
How long ago were you diagnosed with hypertension?	…… (Days/ weeks/ months/ years)	
Do you currently take medication for diabetes?	Yes No	1 0
If no, why not?	Side effect of medicines Cost of medicines Fear of being habitual Lack of trust towards health provider Need to consume lifelong Control via lifestyle modification Other (Specify)…….	0 1 2 3 4 5 96
Where were you diagnosed with diabetes?	…… (Name/ Type of facility)	
How long ago were you diagnosed with diabetes?	…… (Days/ weeks/ months/ years)	
Last time when you visited the ……., what health problems related services did you get?	Hypertension Diabetes Mellitus Other (Specify)……..	1 2 96
What type of services did you receive from the ……?	Prescription of medicines Dispense Counseling Blood pressure checkup Sugar check-up Other (Specify)…….	0 1 2 3 4 96
Please ask the outcome of BP checkup or sugar checkup if they remember.	High blood pressure Normal blood pressure High sugar Normal sugar Can't recall Other (Specify)…….	1 2 3 4 99 96

Did the…….asked you for follow up visit or do repeat measurement of blood pressure in same facility or other facilities?	Yes No	1 0
If yes, in how many days were you asked to repeat measurement ?	……..	
Why did you prefer …….over other health facility such like health post, other urban health centre? (Multiple Choice)	Proximity Affordability Referred by health care providers Recommended by friends/ relatives Prior (good) experience Availability of medicines, equipment and services Short waiting time Good healthcare provider skills Staff shows respect Only facility available Covered or assigned by insurance Other (Specify)……	0 1 2 3 4 5 6 7 8 9 10 96
Since the last time you visited ……, did you visit any other health facilities?	Yes No	1 0
If yes, which facility did you visit ?	……	

Section 3: Cost questionnaire

Household Characteristics	Options	Code
How much money do you spend on your last visit to the ……?		
Consultation Fee/ Registration Charge (in rupees)	…….rupees	
Diagnostic Test (in rupees)	…….rupees	
Medicines for hypertension (in rupees)	…….rupees	
For how many days were the medicines provided for?	…….days	
Medicines for diabetes (in rupees)	…….rupees	
For how many days were the medicines provided for?	…….days	
Travel cost to ……. (both way) [in NRs]	…….rupees	
Do you have to skip your work to seek health care services from the health facility?	Yes No	1 0
How much time was taken to visit to the …… during your last visit ? (sum both ways)	……. (minutes/hour)	

How much waiting time was taken during your last visit to the……..?	…… (minutes/hour)	
How much time was taken to receive the services during your last visit at the …….?	…… (minutes/hour)	
Did the visit reduce your per day earnings?	Yes No Don't know	1 0 98

Section 4: Risk Factors Questionnaire

Tobacco and Alcohol Consumption	Options	Code
Have you ever smoked cigarettes in lifetime?	Yes No	1 0
In past 30 days, how often did you smoke cigarettes ?	Not at all Somedays Everyday	0 1 2
How many days a month?	…….days	
On the days you smoke, on average, how many cigarettes do you smoke each day?	…….. Number of cigarettes	
Do you currently smoke or use any other type of tobacco every day, some days, or not at all?	Not at all Somedays Everyday	0 1 2
What other type of tobacco do you currently smoke or use?	Pipes full of Tobacco/ Sulpha/ Chilum Cigars Water Pipe Chewing Tobacco (Gutka/ Khaini) Betel Quid with Tobacco Vape Bidi Other (Specify)……	0 1 2 3 4 5 6 96
Now I would like to ask you some questions about drinking alcohol.		
Have you ever consumed any alcohol, such as beer, wine, spirits, or local jaand, chyang etc.?	Yes No	1 0

We count one drink of alcohol as one can or bottle of beer, one glass of wine, one shot of spirits, or one cup of jaand, chyang. During the last one month, on how many days did you have at least one drink of alcohol?	Did not have even one drink Every Day/ Almost Every Day Sometimes	0 1 2
Number of days in month	…….days	
In the last one month, on the days that you drank alcohol, how many drinks did you usually have per day?	……. Number of Drinks	
Did you receive any information on tobacco/ alcohol during you last visit to……?	Yes No	1 0
If yes, were all the messages clear for you to understand and act on?	Yes No	1 0
Physical Activity		**Code**
How many times a week do you usually do 20 minutes of vigorous physical activity that makes you sweat or puff and pant? (for example, jogging, heavy lifting, digging, aerobics, or fast bicycling)	None 1-2 times/week 3 times/week >3 times/week	0 1 2 3
How many times a week do you usually do 30 minutes of moderate physical activity or walking that increases your heart rate or makes you breathe harder than normal? (for example, mowing the lawn, carrying light loads, bicycling at a regular pace)	None 1-2 times/week 3- 5 times/week >5 times/week	0 1 2 3
Were you provided any information on exercise/physical activity by the health facility? Prompt: verbal messages, IEC materials	Yes No	1 0
If yes, were all the messages clear for you to understand and act on?	Yes No	1 0
Diet		Code
What do you think that too much salt in your diet can do to your health? (Multiple response)	Nothing, more salt is good for health Increase blood pressure Kidney disease Asthma Cancer Other (Specify)…… Don't know	0 1 2 3 4 96 98
Do you do any of the following on a regular basis to control your salt intake?		
Avoid/ minimize consumption of processed foods such as achaar or papad	Yes No	1 0
Reduced consumption of packaged food like instant noodles, chips in last one week compared to previous lifestyle	Yes No	1 0

Use spices instead of salt when cooking	Yes No	1 0
Eating foods prepared at home only	Yes No	1 0
Eat meals adding extra salt at the table	Yes No	1 0
Cook meals such as pulse, curry adding lesser salt	Yes No	1 0
Were you provided any information on salt intake at ……..?	Yes No	1 0
If yes, were all the messages clear for you to understand?	Yes No	1 0

Section 5: Counselling

Questionnaire	Options	Code
When you visited the …… last time, what information regarding tobacco use was provided? (Please check section 4: Q300)	Harmful effects of smoking Ways to control smoking Social and environmental consequences Economic consequences Benefits of quitting smoking No information was provided Can't remember Other (Specify)…….	0 1 2 3 4 98 99 96
Have you been referred to any specific smoking cessation programs or specialists?	Yes No	1 0
When you visited the ……. last time, what information regarding alcohol use was provided?	Ways to stop drinking alcohols Social and environmental consequences Economic consequences Benefits of quitting smoking No information was provided Can't remember Other (Specify)…….	0 1 2 3 98 99 96
When you visited the ……. last time, what information regarding diet was provided?	Healthy diet High sugar diet High fat diet	0 1 2

	High salt diet No information was provided Can't remember Other (Specify)…….	3 98 99 96
When you visited the …….. last time, what information regarding physical activity was provided?	Types of physical activity Benefits of physical activity At least 150 minutes of moderate- intensity physical activity per week (such as brisk walking, mopping, vacuuming) No information was provided Can't remember Other (Specify)…….	0 1 2 98 99 96

Section 6: Patient Satisfaction Questionnaire

Variables	Strongly Agree	Agree	Disagree	Strongly Disagree
Now I would like to ask your satisfaction when receiving services from…….				
I was satisfied with the overall care provided by my pharmacist.	3	2	1	0
I would recommend that health facility to people I know.	3	2	1	0
If needed, I would continue seeing this health facility for my healthcare needs.	3	2	1	0
The overall care provided by the healthcare providers meet my expectations.	3	2	1	0

Section 7: Medication Adherence

Questions		Code
Do you sometimes forget to take your hypertension/ diabetes mellitus pills?	Yes No	1 0
People sometimes miss taking their medications for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your hypertension/ diabetes mellitus medicine?	Yes No	1 0
Have you ever cut back or stopped taking your medication without telling your doctor, because you felt worse when you took it?	Yes No	1 0
When you travel or leave home, do you sometimes forget to bring along your hypertension/ diabetes mellitus medication?	Yes No	1 0

Did you take your hypertension/ diabetes mellitus medicine yesterday?	Yes No	1 0
When you feel like your hypertension/ diabetes mellitus is under control, do you sometimes stop taking your medicine?	Yes No	1 0
Taking medication everyday is a real inconvenience for some people. Do you ever feel hassled about sticking to your blood pressure treatment plan?	Yes No	1 0
How often do you have difficulty remembering to take all your medications? (Please circle the correct number)	Never/ Rarely Once in a while Sometimes Usually All the time	0 1 2 3 4

Section 8: Follow up and Referral Questionnaire

Questions		Code
Were you referred to another center from the……..?	Yes No	1 0
If yes, where were you referred to?	…… (Name/ Type of health facility)	
Did you ask for the referral yourself?	Yes No	1 0
Did you get the referral slip from ……health facility?	Yes No	1 0
Did you go to the referred health facility after the referral?	Yes No	1 0
If no, what is the reason behind not visiting the referred health facility?	Lack of perceived illness Distance from home Lack of guiding instructions/ reminder Acute health conditions/ disability Long waiting hours Poor quality of medications Convinced by others No time for a visit Other required medicines not available	0 1 2 3 4 5 6 7 8

	Others (Specify)…….	96
If yes, what are the reasons for going to the referred health facility?	Information from …….. health facility Self-awareness Specialized care Others (Specify)……..	0 1 2 96
Do you plan on going to the referred centre in the future?	Yes No	1 0

Section 9: Validation of services

Questionnaire	Options	Code
In your last visit to ……., how many times did the health professional check your blood pressure?	……times	
In your last visit to ……., did the health professional check your blood glucose level?	Yes No	1 0
How many times …….measured blood glucose level ?	……times	
Did the health professional in …….. measured your height?	Yes No	1 0
Did the health professional in …….. measured your weight?	Yes No	1 0
What information regarding the symptoms of diabetes was provided?	Excessive Thirst (Polyuria) Frequent passage of urine (Polyuria) Feeling hungry frequently (Polyphagia) Dry mouth Loss of weight Painful/ burning urination Feeling tired and weak Tingling sensation in hand and feet Blurred vision Didn't give any information Other (Specify)……. Can't Remember	0 1 2 3 4 5 6 7 8 98 96 99

What information regarding the symptoms of hypertension was provided at ……?	Nausea Vomiting Headache Vertigo Epistaxis (nose bleeds) Swelling of hand and feet Difficulty breathing/ Shortness of breath Blurred Vision Didn't give any information Other (Specify)…… Can't Remember	0 1 2 3 4 5 6 7 98 96 99
What information regarding the risk factors of diabetes was provided at ……..?	Unhealthy Diet Lack of physical activity/ Obesity Obesity Smoking of tobacco and use of smokeless tobacco products Alcoholism Growing age Hereditary History of insulin resistance, strokes or hypertension Didn't give any information Other (Specify)……. Can't Remember	0 1 2 3 4 5 6 7 98 96 99
What information regarding the risk factors of hypertension was provided at ……..?	Unhealthy Diet Lack of physical activity Obesity Smoking of tobacco and use of smokeless tobacco products Alcoholism Stress Growing age Gender Hereditary Didn't give any information Other (Specify)……. Can't Remember	0 1 2 3 4 5 6 7 8 98 96 99
What information regarding the complication of diabetes was provided at ……..?	Stroke Retinopathy	0 1

	Cardiomyopathy Proteinuria Neuropathy Diabetic foot Didn't give any information Others Can't Remember	2 3 4 5 98 96 99
What information regarding the complication of hypertension was provided at……?	Renal failure/ chronic kidney disease Heart attack/ left ventricular hypertrophy/ heart failure Epistaxis Stroke Hypertensive Retinopathy Swelling of feet Aneurysm Bleeding Ascites Didn't give any information Others Can't Remember	0 1 2 3 4 5 6 7 98 96 99
Did the health professional in …….provided you instruction about proper ways of consuming the medicine?	Yes No	1 0
Were you provided with any brochure related to health information at …….?	Yes No	1 0
Were the information provided in the brochure easy for you to understand?	Yes No	1 0
Do you think you will be able to follow the advice provided at……?	Yes No	1 0
If not, which advice is most challenging for you to follow?	Tobacco cessation Avoiding alcohol Doing physical activity as recommended Avoiding salt consumption as recommended Adhering to the prescribed medicines Other (Specify)…….	0 1 2 3 4 96
How can health information delivery be improved at the health facility? Prompt: If brochure, leaflets are helpful, get their opinion on how it should look	……..	

Section 10: Socio economic Characteristics

Household Characteristics	Options	Code
How many people are there in your household including yourself?	…… Number of people	
How many rooms that are used as bedrooms are there in your household ?	…….. Rooms	
Do you have a room available to rent to others?	Yes No	1 0
What is dwelling roof made up of?	Zinc/tin/chidar Cement Slope Khar/Paral/Real straw Tile/Khapada/Jhingati Stone/Slate Wood/Wood planks Soil Other (Specify)……	0 1 2 3 4 5 6 96
What are the walls of dwelling made up of?	Brick and stone with soil joints Brick and stone with cement joints Wood/wood planks Bamboo materials Raw/unfired brick Zinc/tin Prefab Block Other (Specify)……..	1 2 3 4 5 6 7 8 96
What is the main source of drinking water for members of your households?	Piped into dwelling Piped to yard/ plot Piped to neighbour Public tap/ Standpipe Tube well or Borehole Protected well Unprotected well Protected Spring Unprotected Spring	0 1 2 3 4 5 6 7 8

	Rainwater Tanker Truck Cart with small tank Surface Water (River/ Dam/ Lake/ Pond/ Stream/ Canal/ Irrigation Channel) Bottled Water Other (Specify)…….	9 10 11 12 13 96
What kind of toilet facility do members of your household usually use? (Ask permission to observe the facility)	Flush Toilet (septic tank) Flush Toilet (public sewerage) Pit Latrine Public Toilet No Toilet Facility Others (Specify)……	1 2 3 4 5 96
Do you share this toilet facility with other households?	Yes No	1 2
If yes, where is this toilet facility located?	In own dwelling In own yard/ plot Elsewhere	1 2 3
Does your household have a handwashing facility?	Yes No	1 0
Does your household have water in the hand-washing place?	Yes No	1 0
Availability of soap, liquid, etc (Ask permission to observe the facility)	Yes No	1 0
Does this household have a television?	Yes No	1 0
Does the household have it's own business?	Yes No	1 0
If yes, is the business registered?	Yes No	1 0
Do you own a agricultural land in Pokhara?	Yes No	1 0
Have you migrated to this area for reasons of economic necessity?	Yes No	1 0
If yes, how many years ago did you migrate?	……years	

What is the highest academic qualification among the household members?	No formal education Lower basic education (1-5) Upper basic education (6-8) Lower secondary (9-10) Higher secondary (11-12) Bachelor's degree Master's Degree or above	0 1 2 3 4 5 6
What is the academic qualification of the household head?	No formal education Lower basic education (1-5) Upper basic education (6-8) Lower secondary (9-10) Higher secondary (11-12) Bachelor's degree Master's Degree or above	0 1 2 3 4 5 6
What is the occupation of the household head?	Services Unskilled Manual Skilled Manual Professional/technical/managerial Agriculture Homemaker Unemployed Other (Specify)……	0 1 2 3 4 5 6 96
How would you rate your neighbours overall in terms of financial and economic?	……	
How would you rate your household compared to your neighbours? (In terms of income and property)	……	

Section 11: Anthropometric Measurements

Anthropometric Measurements	Measurements	Code
First Systolic reading	……. mm of Hg	
Frist Diastolic reading	……. mm of Hg	
Second Systolic reading	……. mm of Hg	

Second Diastolic reading	……. mm of Hg	
Third Systolic reading	……. mm of Hg	
Third Diastolic reading	……. mm of Hg	
Height	…….m	
Weight	……. kg	
BMI	……. Kg/ m^2	
During the past 8 hours have you had anything to eat or drink, other than water?	Yes No	1 0
Blood Glucose level	……..mg/dl	

Client Survey Questionnaire (Follow Up)

Section 1: Demographic Characteristics

Questions	Responses	Code
Name of the respondent	…….	
Age of the respondent	☐☐ (Completed years)	
Gender of the respondent	Male Female Others	1 2 96
Address of the respondent	……. Ward Number	
Tole name	…… Tole	

Section 2: Care seeking behavior

Questions	Options	Code
Do you have health insurance?	Yes No	1 0
Currently, what health problems do you have? (Select multiple if needed)	Hypertension Diabetes Mellitus None Other (Specify)……	0 1 2 96
Do you currently take medication for hypertension?	Yes No	1 0

If no, why not?	Side effect of medicines Cost of medicines Fear of being habitual Lack of trust towards health provider Need to consume lifelong Control via lifestyle modification Other (Specify)…….	0 1 2 3 4 5 96
Where were you diagnosed with hypertension?	…… (Name/ Type of facility)	
How long ago were you diagnosed with hypertension?	…… (Days/ weeks/ months/ years)	
Do you currently take medication for diabetes?	Yes No	1 0
If no, why not?	Side effect of medicines Cost of medicines Fear of being habitual Lack of trust towards health provider Need to consume lifelong Control via lifestyle modification Other (Specify)…….	0 1 2 3 4 5 96
Where were you diagnosed with diabetes?	…….	
How long ago were you diagnosed with diabetes?	…… (Days/ weeks/ months/ years)	

Section 3: Follow up and Referral Questionnaire

Questions		Code
Were you referred to another center from the……..?	Yes No	1 0
If yes, name of the facility		

	…… (Name/ Type of health facility)	
Did you ask for the referral yourself?	Yes No	1 0
Did you get the referral slip from ……health facility?	Yes No	1 0
Did you go to the referred health facility after the referral?	Yes No	1 0
If no, what is the reason behind not visiting the referred health facility?	Lack of perceived illness Distance from home Lack of guiding instructions/ reminder Acute health conditions/ disability Long waiting hours Poor quality of medications Convinced by others No time for a visit Other required medicines not available Others (Specify)…….	0 1 2 3 4 5 6 7 8 96
If yes, what are the reasons for going to the referred health facility?	Information from …….. health facility Information from HERD International field researchers Self-awareness Specialized care Others (Specify)……..	0 1 2 3 96
Do you plan on going to the referred centre in the future?	Yes No	1 0
When you visited the……..health facility, what health problems related services did you get?	Hypertension Diabetes Mellitus Others (Specify)……..	1 2 96
What type of services did you receive from the ……?	Prescription of medicines Dispense Counseling Blood pressure checkup Sugar check-up Other (Specify)…….	0 1 2 3 4 96
Please ask the outcome of BP checkup or sugar checkup if they remember.	High blood pressure Normal blood pressure	1 2

	High sugar Normal sugar Can't recall Others (Specify)…….	3 4 99 96
Since the last time you visited ……, did you visit any other health facilities?	Yes No	1 0
If yes, which facility did you visit ?	……	
If yes, what are the reasons for going to the referred health facility?	Information from HERD International field researchers Self-awareness Specialized care Others (Specify)……..	0 1 2 96
When you visited the……..health facility, what health problems related services did you get?	Hypertension Diabetes Mellitus Others (Specify)……..	1 2 96
What type of services did you receive from the ……?	Prescription of medicines Dispense Counseling Blood pressure checkup Sugar check-up Other (Specify)…….	0 1 2 3 4 96
Please ask the outcome of BP checkup or sugar checkup if they remember.	High blood pressure Normal blood pressure High sugar Normal sugar Can't recall Others (Specify)…….	1 2 3 4 99 96

Section 4: Risk Factors Questionnaire

Tobacco and Alcohol Consumption	Options	Code
Have you ever smoked cigarettes in lifetime?	Yes No	1 0
In past 15 days, how often did you smoke cigarettes ?	Not at all Somedays Everyday	0 1 2

How many days in 15 days?	…….days	
On the days you smoke, on average, how many cigarettes do you smoke each day?	…….. Number of cigarettes	
Do you currently smoke or use any other type of tobacco every day, some days, or not at all?	Not at all Somedays Everyday	0 1 2
What other type of tobacco do you currently smoke or use?	Pipes full of Tobacco/ Sulpha/ Chilum Cigars Water Pipe Chewing Tobacco (Gutka/ Khaini) Betel Quid with Tobacco Vape Bidi Other (Specify)……	0 1 2 3 4 5 6 96
Now I would like to ask you some questions about drinking alcohol.		
Have you ever consumed any alcohol, such as beer, wine, spirits, or local jaand, chyang etc.?	Yes No	1 0
During the last 15 days, on how many days did you have at least one drink of alcohol?	Did not have even one drink Every Day/ Almost Every Day Sometimes	0 1 2
Number of days in the last 15 days	…….days	
In the last one month, on the days that you drank alcohol, how many drinks did you usually have per day?	……. Number of Drinks	
Physical Activity		**Code**
How many times a week do you usually do 20 minutes of vigorous physical activity that makes you sweat or puff and pant? (for example, jogging, heavy lifting, digging, aerobics, or fast bicycling)	None 1-2 times/week 3 times/week >3 times/week	0 1 2 3
How many times a week do you usually do 30 minutes of moderate physical activity or walking that increases your heart rate or makes you breathe harder than normal? (for example, mowing the lawn, carrying light loads, bicycling at a regular pace)	None 1-2 times/week 3- 5 times/week >5 times/week	0 1 2 3
Diet		Code

What do you think that too much salt in your diet can do to your health? (Multiple response)	Nothing, more salt is good for health Increase blood pressure Kidney disease Asthma Cancer Other (Specify)…… Don't know	0 1 2 3 4 96 98
Do you do any of the following on a regular basis to control your salt intake?		
Avoid/ minimize consumption of processed foods such as achaar or papad	Yes No	1 0
Reduced consumption of packaged food like instant noodles, chips in last one week compared to previous lifestyle	Yes No	1 0
Use spices instead of salt when cooking	Yes No	1 0
Eating foods prepared at home only	Yes No	1 0
Eat meals adding extra salt at the table	Yes No	1 0
Cook meals such as pulse, curry adding lesser salt	Yes No	1 0

Section 5: Medication Adherence

Questions		Code
Do you sometimes forget to take your hypertension/ diabetes mellitus pills?	Yes No	1 0
People sometimes miss taking their medications for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your hypertension/ diabetes mellitus medicine?	Yes No	1 0
Have you ever cut back or stopped taking your medication without telling your doctor, because you felt worse when you took it?	Yes No	1 0
When you travel or leave home, do you sometimes forget to bring along your hypertension/ diabetes mellitus medication?	Yes No	1 0
Did you take your hypertension/ diabetes mellitus medicine yesterday?	Yes No	1 0

When you feel like your hypertension/ diabetes mellitus is under control, do you sometimes stop taking your medicine?	Yes No	1 0
Taking medication everyday is a real inconvenience for some people. Do you ever feel hassled about sticking to your blood pressure treatment plan?	Yes No	1 0
How often do you have difficulty remembering to take all your medications? (Please circle the correct number)	Never/ Rarely Once in a while Sometimes Usually All the time	0 1 2 3 4

Section 6: Anthropometric Measurements

Anthropometric Measurements	Measurements	Code
First Systolic reading	……. mm of Hg	
Frist Diastolic reading	……. mm of Hg	
Second Systolic reading	……. mm of Hg	
Second Diastolic reading	……. mm of Hg	
Third Systolic reading	……. mm of Hg	
Third Diastolic reading	……. mm of Hg	
Height	……m	
Weight	……. kg	
BMI	……. Kg/ m^2	
During the past 8 hours have you had anything to eat or drink, other than water?	Yes No	1 0
Blood Glucose level	……..mg/dl	