



YMCA Name: _____
Program Site: _____

BLOOD PRESSURE SELF-MONITORING ENROLLMENT FORM

Today's Date: / /

First name:	Last name:
Phone #: - -	Email:

Preferred contact method: phone email text

Gender: Male Female Prefer not to answer

Date of birth: / /

Have you ever been diagnosed with high blood pressure/hypertension? Yes No

Are you currently taking prescription medication to control or manage your high blood pressure? Yes No

Were you diagnosed in the *last 12 months* with high blood pressure/hypertension? Yes No

Do you have a home blood pressure cuff? Yes No

How did you hear about this program?

- | | |
|---|--|
| <input type="checkbox"/> Y staff member or volunteer | <input type="checkbox"/> A poster, flyer or event at the Y |
| <input type="checkbox"/> A friend or family member or word of mouth | <input type="checkbox"/> The Y's web site |
| <input type="checkbox"/> A doctor or other health care professional | <input type="checkbox"/> Media (TV, web, radio, print, etc.) |
| <input type="checkbox"/> A direct mailing/e-mail communication | <input type="checkbox"/> Other (please specify): |

Are you a member of the Y? Yes No

Are you Hispanic, Latino(a), or Spanish origin? Yes No Prefer not to answer

What is your race:

- | | |
|---|--|
| <input type="checkbox"/> White or Caucasian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Asian | |

What is your highest level of education:

- | | |
|---|---|
| <input type="checkbox"/> Less than high school | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> High school diploma or equivalency (GED) | <input type="checkbox"/> Doctorate |
| <input type="checkbox"/> Associate degree (junior college) | <input type="checkbox"/> Professional (MD, JD, DDS, etc.) |
| <input type="checkbox"/> Bachelor's degree | <input type="checkbox"/> Other (please specify): |

For Y Staff: Baseline Data

Initial BP Measurement:

Systolic BP	<input type="text"/>	Diastolic BP	<input type="text"/>	Arm	<input type="checkbox"/> Right <input type="checkbox"/> Left
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Measurement taken by:

HIPAA form received:	<input type="checkbox"/> Yes	Informed Consent form received:	<input type="checkbox"/> Yes	Auth for Release of Information to Health Care Provider form received:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Program fee that participant paid:	\$
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