FORM NO. 1.2

1. Program Number: 3,4 | 5,6,7,8,9 | 10,11 (1) 006813 (2)

2. Name: (PRINT IN BLOCK CAPITALS) 12,13,14,15,16,17 BATCH NO. 18,19,20,21,22,23,24,25

(Mr., Miss, Mrs.)	Last	First	Middle

3. Date: (3) Month 26,27 Day 28,29 19 Year 30,31 (-2)

4. Time arrived: (4) Hour 32,33 : (5) Minute 34,35 (6) ☐ a.m. ☒ p.m. (12 / 01) (59 / 00) 36

5. Changes required in identifying information: (7) ☐ None ☒ HP11A attached 37

COMPLETE THE SECTION BELOW AT TERMINATION OF VISIT BEFORE PARTICIPANT LEAVES

6. Are special procedures indicated as of this visit?

	Yes	No
Special Tests	☐	☐
Notification of Non-Fatal Event	☐	☐
Toxic Reaction Report	☐	☐

7. Review of completed HPO5:

- ☐ Every item on each page is complete and legible.
- ☐ Name and Program Number are correct.
- ☐ HPO5A, Consent Form for Hypertension Treatment Program, is fully executed and entered in Clinic Record.
- ☐ HPO5B, Release of Medical Information, signed and entered in Clinic Record.
- ☐ HPO5C, Flow Sheet for Blood Pressure, Weight and Medications initiated.
- ☐ Antihypertensive medication was received (or none prescribed).
- ☐ Exit Interview completed by Health Counselor.
- ☐ Appointment slip given:

  Clinic Revisit schedule is:

  - ☐ Step-Up Schedule (2 weeks)
  - ☐ Maintenance Schedule A (4 weeks)
  - ☐ Individualized Therapy (specify interval: _____)

Date of next visit: (-2) (8) Month 38,39 (07) Day 40,41 (31) 19 Year 42,43 (78) (9) Hour 44,45 (07) : (10) Minute 46,47 (58) (11) ☐ a.m. ☒ p.m. 48

8. Time visit completed: (12) Hour 49,50 (12 / 01) : (13) Minute 51,52 (59 / 00) (14) ☐ a.m. ☒ p.m. 53

This section completed by: _____ (15) 54,55 99 0

9. **Blood Pressure Measurements:**

a. Pulse: Beats in 30 seconds _____ x 2 = (16) 56 57 58 beats/minute. 200 / 30

006813

I will be taking six blood pressure readings, four of them while you are seated and two of them just after you stand up.

b. Blood pressure readings:

		Systolic	Diastolic (5th phase)	
Reading 1 (Std)	300 / 60	(17) 59 60 61	(18) 62 63 64 200 / 0	_____
Reading 2 (R-Z)	301 / 60	(19) 65 66 67	(20) 68 69 70 299 / 0	_____
Zero	99 / 0	(21) 71 72	(22) 73 74 99 / 0	
Corrected	300 / 60	(23) 75 76 77	(24) 78 79 80 200 / 0 →	_____
Reading 3 (Std)	300 / 60	(25) 81 82 83	(26) 84 85 86 200 / 0	
Reading 4 (R-Z)	301 / 60	(27) 87 88 89	(28) 90 91 92 299 / 0	+
Zero	99 / 0	(29) 93 94	(30) 95 96 99 / 0	
Corrected	300 / 60	(31) 97 98 99	(32) 100 101 102 200 / 0 →	_____
			(33) 103 104 105 SUM 400 / 0	
Average of Readings 2 and 4		~~MMM~~	~~MMM~~	
Reading 5 (Std) (One minute after standing)	300 / 60	(34) 106 107 108	(35) 109 110 111 200 / 0	
Reading 6 (R-Z) (One minute after standing)	301 / 60	(36) 112 113 114	(37) 115 116 117 299 / 0	
Zero	99 / 0	(38) 118 119	(39) 120 121 99 / 0	
Corrected	300 / 60	(40) 122 123 124	(41) 125 126 127 200 / 0	

c. Is SUM less than 180? No ☒ Yes ☐

(42) 128 Participant is at goal blood pressure.

d. Is the corrected systolic value of Reading 6 lower than the corrected systolic value of Reading 4, by 20, or more?

(43) No ☒ Yes ☐ 129 Is the participant dizzy or faint after standing?

(44) No ☒ Yes ☐ 130 Findings are suggestive of postural hypotension.

e. Remarks:

(45) 131

f. Weight: (46) Pounds 132 133 134 500 / 50

Percent of ideal weight: (From standard table) (47) 135 136 137 152 / 72

(48) 138 139

Observer: _____

HPO5/2

11. Interval Medical History (to be completed by physician):

Comments: 000013

a. How have you been feeling since your last visit?
(Enter comments as necessary.)

49 140

b. Have you started any new medicines, or have you stopped taking any medicines since your last visit?

50 No [2] Yes [1]
141 Describe:

FOR MEN SKIP TO 12.

c. Have you had a menstrual period within the past six weeks?

51 Yes [1] No [2]
142 What is the reason?

52 143
- [1] Post-menopause, natural
- [2] Post-menopause, other → SKIP TO 12.
- [3] Known pregnancy
- [4] Possible pregnancy
- [5] Other, specify: _____ → Order pregnancy test at this visit.

Are you currently taking birth control pills?

53 No [2] Yes [1]
144 Discuss at this visit.

54 145

12. Interval Clinical Findings of Importance (to be completed by physician):

55 146

56 147

Review of Participant's Status:

Comments: 000615

Does the participant have a private physician?

57 No ☐2 Yes ☐1

148

Has the physician been advised of the participant's interest in this Program?

58

149

- ☐1 Yes, and private physician accepts this person's participation.
- ☐2 Yes, but private physician refused this person's participation.
- ☐3 Yes, but result is not known.
- ☐4 No, but participant will contact physician.
- ☐5 No, but Clinic physician will contact private physician.
- ☐6 No, and participant does not wish private physician to be contacted.

Describe details: 59 150

60 151

14. Is the participant already on antihypertensive therapy?

61 No ☐2 Yes ☐1

152 Describe: 62 153

63 154

15. Contraindications and Precautions for Drug Therapy:

		Yes	No
a. Chlorthalidone			
-Is the participant a lactating female?	64	☐1	☐2 155
-Is either of the two serum K+ determinations less than 3.5 mEq/L while the participant is not on diuretics?	65	☐1	☐2 156
-Is either of the two serum K+ determinations less than 3.5 mEq/L, and the participant on digitalis?	66	☐1	☐2 157
-Is either serum uric acid determination greater than 9 mg/dl?	67	☐1	☐2 158
-Is the fasting glucose greater than 150 mg/dl?	68	☐1	☐2 159
-Is the one-hour post-load glucose greater than 180 mg/dl?	69	☐1	☐2 160
b. Spironolactone			
-Is the creatinine greater than 2.0 mg/dl?	70	☐1	☐2 161
-Are both serum K+ determinations greater than 5.0 mEq/L?	71	☐1	☐2 162

72 163

(Continue on next page)

	Yes	No
c. Antiadrenergic drugs (Reserpine, methyldopa)		
-Is there a positive history of peptic ulcer, repeated epigastric distress, or gastrointestinal bleeding?	(73) 1	2 /164
-Is there a positive history of asthma?	(74) 1	2 /165
-Is there a positive history of depression that interfere with work, recreation, or sleep?	(75) 1	2 /166
-Is any liver function test abnormal?	(76) 1	2 /167
d. Hydralazine		
-Is there any evidence of ischemic heart disease?	(77) 1	2 /168

Comments: 006813

Physician's Summary of Precautions and Contraindications:

	Approved	Conditionally Approved	Contra-indicated
1. Chlorthalidone	(78) 1	2	3 /169
2. Spironolactone	(79) 1	2	3 /170
3. Reserpine	(80) 1	2	3 /171
4. Methyldopa	(81) 1	2	3 /172
5. Hydralazine	(82) 1	2	3 /173
6. Guanethidine	(83) 1	2	3 /174
Others, specify: (84) 175,176 01 00			
7. _____	(85) 1	2	3 /177
(86) 178,179 01 00			
8. _____	(87) 1	2	3 /180
(88) 181,182 01 00			
9. _____	(89) 1	2	3 183

(90) 184

Check the following when completed:

☐ Information pertaining to contraindicated drugs, if any, has been transferred to the Flow Sheet (HPO5C).

☐ Information indicated in Item 15 above has been reviewed by the physician, and appropriate items have been verified by discussion with the participant.

16. Initial Therapeutic Regimen:

Comments: 006813

Is the participant to begin, continue or stop any antihypertensive medication as of this visit?

91 No ☐2 Yes ☐1 → 185

	Continue 1	Start 2	Number of pills given at this visit.	Pill size (mg/pill)	Number of pills/dose.	Number of doses/day.	Stop 3
Chlorthalidone	92 ☐ → 186	☐	93 280 0 → 187,188,189	94 100 50 → 190,191,192	95 1 → 193	96 1 → 194	☐
			98 280 0	99 25 25	100 4 1	101 4 1	
Spironolactone	97 ☐ → 195	☐	196,197,198	199,200,201	202	203	☐
			108 280 0	104 25 12	105 4 1	106 4 1	
Reserpine	102 ☐ → 204	☐	205,206,207	0. 208,209	210	211	☐
			108 280 0		168 4 1	110 4 1	
Regroton®	107 ☐ → 212	☐	213,214,215		216	217	☐
			112 280 0	113 50 50	114 4 1	115 4 1	
Methyldopa	111 ☐ → 218	☐	219,220,221	222,223,224	225	226	☐
			117 280 0	118 50 10	119 4 1	120 4 1	
Hydralazine	116 ☐ → 227	☐	228,229,230	231,232,233	234	235	☐
			122 280 0	123 25 10	124 4 1	125 4 1	
Guanethidine	121 ☐ → 236	☐	237,238,239	240,241	242	243	☐
			128 280 0	129 999 0	130 4 1	131 4 1	
Other specify: 126 244, 245	127 ☐ → 246	☐	247,248,249	250,251,252	253	254	☐
			134 280 0	135 999 0	136 4 1	137 4 1	
132 255, 256	133 ☐ → 257	☐	258,259,260	261,262,263	264	265	☐
			138 ☐1 None → 266				

139 267

17. Has the Consent Form for Hypertension Treatment Program (HP05A) been fully executed?

140 Yes ☐1 No ☐2 → 268 Explain: 141 269

142 270

18. On the basis of all information available at this time, does this participant have:

a. A new indication for any Special Test?

143 ☐1 Yes, entered on Special Tests form (HP10)

271 ☐2 No

144 272

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18. b. A new condition requiring notification of non-fatal event (myocardial infarction, stroke, or hospitalization)?

145 / 273
- [1] Yes, Notification of Non-Fatal Event (HPO8) initiated
- [2] No

c. A new condition suggesting a critical toxic reaction, due to therapy from non-HDFP sources?

146 / 274
- [1] Yes, Toxic Reaction Report (HPO9) attached
- [2] No

19. The Clinic Revisit schedule is:

147 / 275
- [1] Step-Up Schedule (2 weeks)
- [2] Maintenance Schedule A (4 weeks)
- [3] Individualized Therapy (specify interval: 276.277) 148 28 1

Comments:

149 278

20. Remarks on further management plans, diagnostic evaluation or other matters:

150 279

152 Century Date 28 2 86

151 280.281 99 0

Physician _____

Consent Form for Hypertension Treatment Program

The Special Hypertension Treatment Program at the _____ has been explained to me, and I understand that I am invited to take part in it.

The purpose of the Program, the procedures to be followed, the attendant possible discomforts and risks, and expected benefits have been described to me. In addition, it has been explained to me that high blood pressure (hypertension) is a common condition which results in increased risk of heart disease and stroke. I further understand that:

1) My high blood pressure and its effect on my body will be judged by the use of standard medical tests and measurements. As long as my blood pressure remains higher than is considered normal, medications will be given to lower it.

2) There are several oral medications which are generally effective in reducing high blood pressure in most cases and that treatment with these medicines is likely to be beneficial in reducing the risk of heart disease and stroke.

3) Several different medications may be used, either singly or in combination, in order to lower my blood pressure to a satisfactory level. All medications used will be standard medications which are commonly used by doctors who have special experience in treating high blood pressure patients. No new or "experimental" medications will be used in this Program.

4) There may be side effects with respect to the use of these medicines, such as rashes, stomach upset, other allergic reactions, and other side effects. The possible side effects that may occur with the medicines that I will be put on at this time have been explained to me as well as the fact that I can ask any questions about these possible side effects and any other aspect of the procedures that I do not understand. Furthermore, the doctor, therapist, nurses and others involved in my treatment under this Program will watch closely for such side effects and when necessary will stop the medication which appears to be responsible if such side effects occur and will give me new medication.

5) Should I require different or stronger medications to lower my blood pressure than I receive at first, my doctor will inform me of any different side effects that these different medications may produce. Furthermore, if a specific cause for my high blood pressure is found by the standard medical tests that I have taken, alternative procedures which may be advantageous to me will be explained.

I understand that I am free to withdraw my consent and to discontinue participation in this Program at any time. These foregoing points have all been explained to me to my satisfaction and, understanding them fully, I hereby give my consent to enter this treatment Program.

_____ _____

Date Signature of Participant

_____

Printed Name of Participant

_____

Address of Participant

_____

Witness (recommended)

I have fully explained to the participant, _____, the nature and purpose of the procedures described above and such risks as are involved in their performance.

_____ _____

Date Signature of Physician

RELEASE OF MEDICAL INFORMATION

I, the undersigned, authorize the sources listed below to provide clinical records to the _____

_____ Center of the Hypertension Detection and Follow-up Program.

(a) Dr. _____

Address _____

_____

(b) Institution (s):

Name _____

Address _____

_____

Name _____

Address _____

_____

_____
Signature of Participant

_____
Printed Name of Participant

_____
Date