

HP04: Second Clinic Visit Form

Purpose

The *Second Clinic Visit* was scheduled during the First Clinic Visit (HP03). All persons found blood pressure eligible during the First Clinic Visit were asked to return for a physical examination and randomization. See **Section 4.6** of the *Manual of Operations* for detailed instructions on the HP04.

Special Considerations

- The standardized physical examination is described in **Section 8.4** of the HDFP *Manual of Operations*.

Form No. 1.2

1. Program Number: 3.4 5.6.7.8.9 10.11 1

003214 2

Name: (PRINT IN BLOCK CAPITALS) 12.13.14.15.16.17. BATCH NO. 18.19.20.21.22.23.24.25 ACROSTIC

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

3 Date: Month 26.27 Day 28.29 Year 30.31

4 Time arrived: 4 Hour 32.33 : 5 Minute 34.35 6 a.m. p.m. 36

5. Changes required in identifying information: 7 None HP11A attached 37

COMPLETE THE SECTION BELOW AT TERMINATION OF VISIT BEFORE PARTICIPANT LEAVES

6. Randomization determined: 8 RCG SCG 9 Envelope Number: 39.40 41.42.43.44 142000 010001

7. Review of completed HPO4:

- Every item on each page is complete and legible.
Name, Program Number and Randomization Envelope Number are correct.
Chest x-ray completed.
HP12, Clinical Center Laboratory Report, initiated and entered in Clinic Record.
Fasting blood specimen obtained.
One-hour blood specimen obtained.

10 RCG Participants: 45 7 Diastolic blood pressure less than 125: Participant referred. 2 Diastolic blood pressure 125 or more: Special measures started.

SCG participants: Special tests are not indicated at present. Special tests have been ordered; HP10 initiated and attached to Clinic Record. Initial Treatment Visit scheduled, Date: 11 12 13 14 Month Day Year Hour Minute 46.47 48.49 19 50.51 52.53 : 54.55 a.m. p.m. 56 Appointment slip given. Clinic Medical Record complete.

8. Time visit completed: 15 Hour 57.58 : 16 Minute 59.60 17 a.m. p.m. 61

This section completed by: 18 6263

9. Interval Medical History:

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

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19 64

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

No Yes 20
65 Describe:

21 66

FOR MEN SKIP TO 10.

c. Are you currently taking birth control pills?

No Yes 22
67

10 Blood Pressure Measurements:

23

200
30

a. Pulse: Beats in 30 seconds _____ x 2 = 68.69.70 beats/minute.

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

Blood pressure readings:

		Systolic	Diastolic (5th phase)	
Reading 1 (Std)	300 60	24 <u>71.72.73</u>	25 <u>74.75.76</u>	200 0
Reading 2 (R-Z)	301 60	26 <u>77.78.79</u>	27 <u>80.81.82</u>	299 0
Zero	99 0	28 <u>83.84</u>	29 <u>85.86</u>	99 0
Corrected	300 60	30 <u>87.88.89</u>	31 <u>90.91.92</u>	200 0 →
Reading 3 (Std)	300 60	32 <u>93.94.95</u>	33 <u>96.97.98</u>	200 0
Reading 4 (R-Z)	301 60	34 <u>99.100.101</u>	35 <u>102.103.104</u>	299 0 +
Zero	99 0	36 <u>105.106</u>	37 <u>107.108</u>	99 0
Corrected	300 60	38 <u>109.110.111</u>	39 <u>112.113.114</u>	200 0 →
Average of Readings 2 and 4			40 <u>115.116.117</u>	400 0 SUM
Reading 5 (Std) (One minute after standing)	300 60	41 <u>118.119.120</u>	42 <u>121.122.123</u>	200 0
Reading 6 (R-Z) (One minute after standing)	301 60	43 <u>124.125.126</u>	44 <u>127.128.129</u>	299 0
Zero	99 0	45 <u>130.131</u>	46 <u>132.133</u>	99 0
Corrected	300 60	47 <u>134.135.136</u>	48 <u>137.138.139</u>	200 0

c. Is SUM less than 180? No Yes
 49 140 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?

e. Remarks:

50 No Yes
 141 Is the participant dizzy or faint after standing?

52 143

51 No Yes
 142 Findings are suggestive of postural hypotension.

53 Pounds
 144 145 146 500
 50

11. Weight:

Observer: _____ 54 147.148 99

PARTICIPANT SHOULD NOW BE SENT TO THE LAB FOR DRAWING OF BLOOD SAMPLE AND ADMINISTRATION OF GLUCOSE LOAD.

PHYSICAL EXAMINATION

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Area Examined

Description of Findings

<p>12. GENERAL APPEARANCE:</p>	<p>Abnormal <input type="checkbox"/> Normal <input checked="" type="checkbox"/></p> <p style="text-align: center;">149</p>	<p style="border: 1px solid black; padding: 5px; display: inline-block;">56 150</p>
<p>13. SKIN:</p>	<p>Abnormal <input type="checkbox"/> Normal <input checked="" type="checkbox"/></p> <p style="text-align: center;">151</p>	<p style="border: 1px solid black; padding: 5px; display: inline-block;">59 153</p>
<p>Xanthomata:</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p style="text-align: center;">152</p>	
<p>14. EARS, NOSE AND THROAT:</p>	<p>Abnormal <input type="checkbox"/> Normal <input checked="" type="checkbox"/></p> <p style="text-align: center;">154</p>	<p style="border: 1px solid black; padding: 5px; display: inline-block;">61 155</p>
<p>15. EYES:</p>	<p>Abnormal <input type="checkbox"/> Normal <input checked="" type="checkbox"/></p> <p style="text-align: center;">156</p>	<p style="border: 1px solid black; padding: 5px; display: inline-block;">74 171</p>
<p>a. Scleral icterus:</p>	<p>No <input checked="" type="checkbox"/> Yes <input type="checkbox"/></p> <p style="text-align: center;">157</p> <p>Initiate Special Tests (HP10).</p>	
<p>b. Arteriolar spasm/focal constriction:</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p style="text-align: center;">158</p>	
<p>c. A-V nicking:</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p style="text-align: center;">159</p>	
<p>d. Hemorrhages:</p>	<p>No <input checked="" type="checkbox"/> Yes <input type="checkbox"/></p> <p style="text-align: center;">160</p> <p>Affecting 2 or more quadrants of the same eye?</p>	
	<p>No <input checked="" type="checkbox"/> Yes <input type="checkbox"/></p> <p style="text-align: center;">161</p> <p>Confirmed by:</p>	
	<p style="text-align: center;">162, 163 99 0</p>	
<p>e. Exudates:</p>	<p>Absent <input type="checkbox"/> Hard <input checked="" type="checkbox"/> Soft <input checked="" type="checkbox"/></p> <p style="text-align: center;">164</p> <p>Confirmed by:</p>	<p style="border: 1px solid black; padding: 5px; display: inline-block;">70 99 0</p>
<p>f. Papilledema:</p>	<p>No <input checked="" type="checkbox"/> Yes <input type="checkbox"/></p> <p style="text-align: center;">167</p> <p>Confirmed by:</p>	
	<p style="text-align: center;">99 0 168, 169</p>	
	<p style="text-align: center;">170</p>	
	<p style="text-align: center;">73</p>	

Check if pupils dilated for fundoscopic exam:

16. NECK:

	Abnormal		Normal	
	<input type="checkbox"/>	172	<input checked="" type="checkbox"/>	
a. Abnormal venous distension present:	Yes		No	
	<input type="checkbox"/>		<input checked="" type="checkbox"/>	
b. Carotid bruits:	Right	173	Left	Both
	<input type="checkbox"/>		<input checked="" type="checkbox"/>	3
c. Diminished carotid pulsations:	Right	174	Left	
	<input type="checkbox"/>		<input checked="" type="checkbox"/>	3
		175		

79 176

17. LYMPH NODES:

	Abnormal		Normal
	<input type="checkbox"/>	177	<input checked="" type="checkbox"/>

81 178

18. CHEST AND LUNGS:

	Abnormal		Normal
	<input type="checkbox"/>	179	<input checked="" type="checkbox"/>
Râles:	Yes		No
	<input type="checkbox"/>		<input checked="" type="checkbox"/>
		180	

84 181

19. HEART:

	Abnormal		Normal
	<input type="checkbox"/>	182	<input checked="" type="checkbox"/>
a. Abnormal apical impulse:	Yes		No
	<input type="checkbox"/>		<input checked="" type="checkbox"/>
b. Irregular apical heart rate:	<input type="checkbox"/>	183	<input checked="" type="checkbox"/>
c. Heart rate greater than 100/minute:	<input type="checkbox"/>	184	<input checked="" type="checkbox"/>
d. S 3 gallop:	<input type="checkbox"/>	185	<input checked="" type="checkbox"/>
e. Systolic murmur:	<input type="checkbox"/>	186	<input checked="" type="checkbox"/>
f. Diastolic murmur:	<input type="checkbox"/>	187	<input checked="" type="checkbox"/>
		188	

92 189

20. ABDOMEN:

	Abnormal		Normal
	<input type="checkbox"/>	190	<input checked="" type="checkbox"/>
a. Hepatomegaly:	No		Yes
	<input checked="" type="checkbox"/>		<input type="checkbox"/>
		191	
			Initiate Special Tests (HP10).
b. Upper abdominal bruit:	No		Yes
	<input checked="" type="checkbox"/>		<input type="checkbox"/>
		192	
			Initiate Special Tests (HP10) if indicated.

96 193

21. EXTREMITIES:

a. Definite ankle edema:

	Abnormal	Normal
97	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	194	
	Yes	No
98	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	195	

b. Pulses present:

posterior tibial

dorsalis pedis

femoral (only if posterior tibial and dorsalis pedis pulses are both missing)

	Right	Left
99	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	196	
100	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	197	
101	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	198	

Both

3

3

3

102 199

22. NEUROLOGICAL:

a. Hemiplegia:

b. Gross hemiparesis:

	Abnormal	Normal
103	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	200	
	Right	Left
104	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	201	
	Right	Left
105	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	202	

Both

3

3

106 203

23. OTHER PHYSICAL FINDINGS, SPECIFY:

107 204

Physical examination by: _____

108

205 206

9
0

a. Physician's Diagnoses: (List significant findings in order of importance.)

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109 207

b. Diagnostic Check List:

Malignant Neoplasm:	Present	Suspect	No Evidence	Circulatory Disease:	Present	Suspect	No Evidence
Breast	<input checked="" type="checkbox"/> 116	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> 208	Rheumatic	<input checked="" type="checkbox"/> 116	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> 208
Lung	<input checked="" type="checkbox"/> 117	<input type="checkbox"/>	<input type="checkbox"/> 209	Other valvular	<input checked="" type="checkbox"/> 117	<input type="checkbox"/>	<input type="checkbox"/> 209
GI	<input checked="" type="checkbox"/> 118	<input type="checkbox"/>	<input type="checkbox"/> 210	Ischemic	<input checked="" type="checkbox"/> 118	<input type="checkbox"/>	<input type="checkbox"/> 210
GU	<input checked="" type="checkbox"/> 119	<input type="checkbox"/>	<input type="checkbox"/> 211	Hypertensive heart	<input checked="" type="checkbox"/> 119	<input type="checkbox"/>	<input type="checkbox"/> 211
Skin	<input checked="" type="checkbox"/> 120	<input type="checkbox"/>	<input type="checkbox"/> 212	Peripheral vascular	<input checked="" type="checkbox"/> 120	<input type="checkbox"/>	<input type="checkbox"/> 212
Other, specify:	<input checked="" type="checkbox"/> 116	<input type="checkbox"/>	<input type="checkbox"/> 213	Cerebrovascular	<input checked="" type="checkbox"/> 121	<input type="checkbox"/>	<input type="checkbox"/> 213
<p>Endocrine Metabolic Disease:</p>				<p>Respiratory Disease:</p>			
Diabetes	<input checked="" type="checkbox"/> 125	<input type="checkbox"/>	<input type="checkbox"/> 215	Chronic obstructive lung disease	<input checked="" type="checkbox"/> 125	<input type="checkbox"/>	<input type="checkbox"/> 215
Gout	<input checked="" type="checkbox"/> 126	<input type="checkbox"/>	<input type="checkbox"/> 216	Asthma	<input checked="" type="checkbox"/> 126	<input type="checkbox"/>	<input type="checkbox"/> 216
Hyperthyroidism	<input checked="" type="checkbox"/> 127	<input type="checkbox"/>	<input type="checkbox"/> 217	Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input checked="" type="checkbox"/> 128	<input type="checkbox"/>	<input type="checkbox"/> 218	active	<input checked="" type="checkbox"/> 128	<input type="checkbox"/>	<input type="checkbox"/> 218
Cushing's syndrome	<input checked="" type="checkbox"/> 129	<input type="checkbox"/>	<input type="checkbox"/> 219	inactive	<input checked="" type="checkbox"/> 129	<input type="checkbox"/>	<input type="checkbox"/> 219
Pheochromocytoma	<input checked="" type="checkbox"/> 130	<input type="checkbox"/>	<input type="checkbox"/> 220	Other, specify:	<input checked="" type="checkbox"/> 130	<input type="checkbox"/>	<input type="checkbox"/> 220
Primary aldosteronism	<input checked="" type="checkbox"/> 131	<input type="checkbox"/>	<input type="checkbox"/> 221	<p>Digestive Disease:</p>			
Other, specify:	<input checked="" type="checkbox"/> 125	<input type="checkbox"/>	<input type="checkbox"/> 222	Peptic ulcer	<input checked="" type="checkbox"/> 131	<input type="checkbox"/>	<input type="checkbox"/> 222
<p>Mental Disease:</p>				<p>Genito-Urinary Conditions:</p>			
Psychosis	<input checked="" type="checkbox"/> 132	<input type="checkbox"/>	<input type="checkbox"/> 224	Nephritis/Nephrosis	<input checked="" type="checkbox"/> 132	<input type="checkbox"/>	<input type="checkbox"/> 224
Psychoneurosis	<input checked="" type="checkbox"/> 133	<input type="checkbox"/>	<input type="checkbox"/> 225	Pregnancy	<input checked="" type="checkbox"/> 133	<input type="checkbox"/>	<input type="checkbox"/> 225
Mental retardation	<input checked="" type="checkbox"/> 134	<input type="checkbox"/>	<input type="checkbox"/> 226	Urinary tract infection	<input checked="" type="checkbox"/> 134	<input type="checkbox"/>	<input type="checkbox"/> 226
Alcoholism	<input checked="" type="checkbox"/> 135	<input type="checkbox"/>	<input type="checkbox"/> 227	Nephrolithiasis	<input checked="" type="checkbox"/> 135	<input type="checkbox"/>	<input type="checkbox"/> 227
Drug addiction	<input checked="" type="checkbox"/> 136	<input type="checkbox"/>	<input type="checkbox"/> 228	Other, specify:	<input checked="" type="checkbox"/> 136	<input type="checkbox"/>	<input type="checkbox"/> 228
Depression	<input checked="" type="checkbox"/> 137	<input type="checkbox"/>	<input type="checkbox"/> 229	<p>Other Diseases Specify:</p>			
Other, specify:	<input checked="" type="checkbox"/> 133	<input type="checkbox"/>	<input type="checkbox"/> 230	Arthritis or rheumatism	<input checked="" type="checkbox"/> 137	<input type="checkbox"/>	<input type="checkbox"/> 230
<p>Neurologic Disease:</p>				<p>Musculo-Skeletal Disease:</p>			
Convulsive disorder	<input checked="" type="checkbox"/> 138	<input type="checkbox"/>	<input type="checkbox"/> 232	Other, specify:	<input checked="" type="checkbox"/> 138	<input type="checkbox"/>	<input type="checkbox"/> 232
Other, specify:	<input checked="" type="checkbox"/> 136	<input type="checkbox"/>	<input type="checkbox"/> 233	<p>Other Diseases Specify:</p>			
<p>Musculo-Skeletal Disease:</p>				<p>Other Diseases Specify:</p>			
Arthritis or rheumatism	<input checked="" type="checkbox"/> 139	<input type="checkbox"/>	<input type="checkbox"/> 235	Other, specify:	<input checked="" type="checkbox"/> 139	<input type="checkbox"/>	<input type="checkbox"/> 235
Other, specify:	<input checked="" type="checkbox"/> 139	<input type="checkbox"/>	<input type="checkbox"/> 236	<p>Other Diseases Specify:</p>			

25. Review of results of examination - Discussion with participant:

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- General explanation of high blood pressure.
- Present status of individual in terms of risk factors:
 - Blood pressure and end-organ status

- 270 (172) Smoking (if greater than 10 cigarettes per day)
- 271 (173) Cholesterol (if greater than 250 mg/dl)
- 272 (174) Percent of ideal weight (if 140% or greater)
- Explanation of Referral

If Regular Care Group:

a. Participant's choice of care,

specify: 175 273

b. Results to be sent to physician:

- | | |
|--------------------------|---|
| No | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> |
| | ↓ |
| | Release of Program
Information (HPO3A) signed. |
| | <input type="checkbox"/> |

If Stepped Care Group:

a. Mode of contacting private physician:

- 176 Participant to contact
- 176 Program to contact
- 274 Participant does not wish to contact doctor.
- 176 No doctor to contact

b. Are Special Tests required?

- | | | |
|-----|--|------------------------------|
| 177 | No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> |
| 275 | Enter on Special Tests form (HP 48) | |

26. If participant is currently using medications and has brought them for identification at this visit describe (do not repeat entries listed under 21b., HPO3/10):

	<u>Reason for medication</u>	<u>When started</u>	<u>Identification</u>
(1)	_____	_____	_____
(2)	178 276-277	_____	_____
(3)		_____	_____
(4)		_____	_____
(5)		_____	_____

Reviewing physician: _____

(179) 278, 277 99
C