J. Side Effects, complete for each event reported

Date Event Started (DD/MM/YY)	Date Event Stopped (DD/MM/YY)	Effect Type: Cough	Angioedema	Acute kidney injury	Electrolyte abnormality	Syncope	Dizziness	Required medical treatment
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No
___/___/___	___/___/___	☐	☐	☐	☐	☐	☐	☐Yes ☐No

K. Serious Adverse Events

Date Event Started (DD/MM/YY)	Date Event Stopped (DD/MM/YY)	Event Description
___/___/___	___/___/___	
___/___/___	___/___/___	
___/___/___	___/___/___	
___/___/___	___/___/___	

L. Referrals & Comments

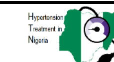
Date (DD/MM/YY)	Referral	Comment (if referred, where and what for)
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	
___/___/___	☐Yes ☐No	

J. Patient Status

☐Active ☐Dead (Date: ___/___/___) ☐Migrated (Date: ___/___/___)

☐Unresponsive (Date: ___/___/___) ☐Inactive (Date: ___/___/___)

HTN Treatment Card

V1.2, 27 January 2020 

A. Facility Information

Council Area:	Health Center ID:
Registration date (DD/MM/YY): ___/___/___	PHC Name / Ward:

B. Patient Identification Information

Program ID#:	Surname:	First Name:

Unique ID #:	1st Phone Number:
Next of Kin Name:	Next of Kin Phone Number:

Sex: ☐Male ☐Female | Birth Date (DD/MM/YYYY): ___/___/_____ | Height: ___ cm

Education Level: ☐Never attended school ☐Primary School ☐Secondary School ☐High School ☐College/University ☐Professional Degree ☐Other: __________

C. Diagnosis & Co-morbidity

Event/Condition	At registration: Yes	No	Unknown	Date, if known (MM/YY)	During Program: New Event	Date, if known (DD/MM/YY)
Hypertension diagnosis	☐	☐	NA	___/___	NA	NA
Diabetes mellitus diagnosis	☐	☐	☐	___/___	☐	___/___/___
Heart failure diagnosis	☐	☐	☐	___/___	☐	___/___/___
Chronic kidney disease diagnosis	☐	☐	☐	___/___	☐	___/___/___
Prior stroke	☐	☐	☐	___/___	☐	___/___/___
Prior heart attack	☐	☐	☐	___/___	☐	___/___/___
Angiotensin Receptor Blocker Allergy	☐	☐	☐	___/___	☐	___/___/___
History of smoking/tobacco	☐	☐	☐	☐Current ☐Former	☐Less than 1x per week ☐Less than 1x per day ☐More than 1x per day	
History of alcohol use	☐	☐	☐	☐Current ☐Former	☐Less than 1 bottle per week ☐Between 1 bottle per week and 1 bottle per day ☐More than 1 unit per day	

D. Pregnancy, complete among women only for each new pregnancy including current pregnancy at registration

Pregnant at registration: ☐Yes ☐No	Date of delivery or cessation: ___/___/_____
Visit date with new pregnancy: ___/___/_____	Date of delivery or cessation: ___/___/_____
Visit date with new pregnancy: ___/___/_____	Date of delivery or cessation: ___/___/_____

E. Hypertensive medications taken at baseline, complete one line per medication

How long has the drug been taken?	Drug	Dose	Other Drug	Stop Date (DD/MM/YY)
☐Less than 1 year ☐1 to 5 years ☐More than 5 years	☐Amlodipine ☐Losartan ☐Hydrochlorothiazide	☐5 mg ☐50 mg ☐10 mg ☐100 mg ☐25 mg	Name: __________ Dose: __________	___/___/___
☐Less than 1 year ☐1 to 5 years ☐More than 5 years	☐Amlodipine ☐Losartan ☐Hydrochlorothiazide	☐5 mg ☐50 mg ☐10 mg ☐100 mg ☐25 mg	Name: __________ Dose: __________	___/___/___
☐Less than 1 year ☐1 to 5 years ☐More than 5 years	☐Amlodipine ☐Losartan ☐Hydrochlorothiazide	☐5 mg ☐50 mg ☐10 mg ☐100 mg ☐25 mg	Name: __________ Dose: __________	___/___/___
☐Less than 1 year ☐1 to 5 years ☐More than 5 years	☐Amlodipine ☐Losartan ☐Hydrochlorothiazide	☐5 mg ☐50 mg ☐10 mg ☐100 mg ☐25 mg	Name: __________ Dose: __________	___/___/___

F. Blood Pressure Measures, complete 2 blood pressure measures at each visit including registration

Visit Date (DD/MM/YY)	Weight, kg	SBP, mmHg	DBP, mmHg	SBP, mmHg	DBP, mmHg	Heart rate, bpm	Med Change	Side Effect	Next Visit Date (DD/MM/YY)
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___
___/___/___	___	___	___	___	___	___	☐Yes ☐No	☐Yes ☐No	___/___/___

G. Hypertensive medications prescribed, complete one line per medication, when medications are changed, update this section.

Date Prescribed (DD/MM/YY)	Amlodipine	Losartan	Hydrochlo-rothiazide	Other	Reason Stopped		Stop Date (DD/MM/YY)
___/___/___	☐5 mg ☐10 mg	☐50 mg ☐100 mg	☐12.5 mg ☐25 mg	Name:___ Dose:___	☐Contraindicated ☐Side Effects ☐Dose Changed	☐Other: ___	___/___/___
___/___/___	☐5 mg ☐10 mg	☐50 mg ☐100 mg	☐12.5 mg ☐25 mg	Name:___ Dose:___	☐Contraindicated ☐Side Effects ☐Dose Changed	☐Other: ___	___/___/___
___/___/___	☐5 mg ☐10 mg	☐50 mg ☐100 mg	☐12.5 mg ☐25 mg	Name:___ Dose:___	☐Contraindicated ☐Side Effects ☐Dose Changed	☐Other: ___	___/___/___
___/___/___	☐5 mg ☐10 mg	☐50 mg ☐100 mg	☐12.5 mg ☐25 mg	Name:___ Dose:___	☐Contraindicated ☐Side Effects ☐Dose Changed	☐Other: ___	___/___/___
___/___/___	☐5 mg ☐10 mg	☐50 mg ☐100 mg	☐12.5 mg ☐25 mg	Name:___ Dose:___	☐Contraindicated ☐Side Effects ☐Dose Changed	☐Other: ___	___/___/___
___/___/___	☐5 mg ☐10 mg	☐50 mg ☐100 mg	☐12.5 mg ☐25 mg	Name:___ Dose:___	☐Contraindicated ☐Side Effects ☐Dose Changed	☐Other: ___	___/___/___

H. Counseling, complete each time counseling is provided

Date of Counseling (DD/MM/YY)	Diet	Activity	Alcohol	Tobacco	Medication Adherence	Other
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___
___/___/___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	___

I. Lab Data, complete each time new lab data are available

Results Date (DD/MM/YY)	Serum creatinine, mg/dL	Serum potassium, mEq/L	Serum sodium, mEq/L	Total cholesterol, mg/dL	Spot microalbumin, mg	Hemoglobin A1C, %
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _
___/___/___	___ . _ ☐μmol/l	__ . _ ☐mmol/l	___☐mmol/l	___ ☐mmol/l	___	__ . _