**DATA COLLECTION FORM**

1. **IDENTIFICATION OF PATIENT**

|  |  |  |
| --- | --- | --- |
| NAME: | SEX: | WEIGHT: |
| AGE: | OCCUPATION: | MARITAL STATUS: |

SOCIAL HABITS: Alcohol Smoking Chewing tobacco

* What is the highest education you received?

Not at all Elementary High school Graduate /professional degree

|  |
| --- |
| Present illness / comorbid condition: |

* Vitals:

|  |  |
| --- | --- |
| Temperature |  |
| Blood pressure |  |
| Pulse rate |  |
| RBS |  |
| Cholesterol levels |  |

* How many medications do you take daily?
* What are the symptoms you have experienced ?

|  |
| --- |
|  |

* Severity of symptoms:

 mild  moderate  severe

1. Do you get the kind of support from family and friends you need?

Yes No

1. Do you have enough money to meet your needs?

Yes No

1. Are you satisfied with your health?

Yes No

1. Do you need any medical treatment to function in your daily life?

 Yes  No

1. Are you satisfied with your ability to perform your daily living activities?

Yes No

1. Activities of daily living:

|  |  |  |  |
| --- | --- | --- | --- |
| Activities | Independent | Require assistance | Dependent |
| Walking |  |  |  |
| Dressing |  |  |  |
| Bathing |  |  |  |
| Eating |  |  |  |
| Toileting |  |  |  |

1. Instrumental activities of daily living:

|  |  |  |  |
| --- | --- | --- | --- |
| Instrumental activities | Independent | Require assistance | Dependent |
| Managing finances |  |  |  |
| Driving |  |  |  |
| Shopping |  |  |  |
| House cleaning and maintenance |  |  |  |
| Food preparation |  |  |  |
| Managing of communication |  |  |  |
| Taking medication |  |  |  |

1. Are you satisfied with your access to health services?

 Yes  No

1. Are you able to concentrate on daily activities?

 Yes  No

1. Do you have enough energy for everyday activities?

 Yes  No

1. Do you have negative feelings such as mood swings, anxiety, depression, hallucinations?

 Yes  No

1. Are you satisfied with your sleep?

 Yes  No

1. Do you have poor eyesight?

 Yes  No

1. Do you take any OTC or herbal medications other than prescribed?

 Yes  No

1. Do you take all your prescribed medications?

 Yes  No

1. Do you have blood relatives with history of hypertension or diabetes?

 Yes  No

1. Over the last year have been admitted to the hospital ?

 Yes  No

1. I) Have you had any complications from your hypertension?

 No  yes  I don’t know

If yes what is the complication?

II) Have you had any complications from your diabetes mellitus?

 No  yes  I don’t know

If yes what is the complication?

1. Have you had lack of appetite, nausea, satiety?

 Yes  No

1. Have you had any of the following problems?

 dizziness (on sitting, standing )  headache  SOB

 tiredness  palpitations or racing heart  involuntary movements

 frequent thirst  frequent urination  dry mouth

 blurred vision  pedal edema  numbness or tingling sensation

 leg cramps  dry, hacking cough  constipation  diarrhea

 tinnitus  slurred speech

1. How often will you have your health checkup regarding your health condition?

 daily  weekly  monthly  half yearly  never

1. Do you have trouble with control of your bowel and bladder movements?

 yes  No

1. Will you follow precautions and take selfcare regarding your health condition?

 yes  No

1. Have you experienced any adverse effects on taking medications?

 Yes  No

If yes,

* What is the adverse effect?
* Which medication caused an adverse effect?
* How many times have you taken the medication before onset of an adverse effect?

1. Is the quality of life affected?

 Yes  No