Visit 2

EARNEST

Patient Details

Participant Initials: ☐☐☐ **Subject ID:** ☐☐☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐

Visit Details

Visit V2 **Visit Date** ☐☐ / ☐☐ / ☐☐

ANTHROPOMETRIC MEASUREMENTS

Weight ☐☐☐.☐ (Kg)

MEDICAL HISTORY

Have you had any of the following since your last visit 12 months ago:

1. **High Blood Pressure** ☐ **Yes** ☐ No

If YES, enter start month e.g. Jan / YY ☐☐☐ / ☐☐

2. **Diabetes** ☐ **Yes** ☐ No

If YES, month/year diagnosed ☐☐☐ / ☐☐

3. **Stroke or TIA** ☐ **Yes** ☐ No

If YES, month/year diagnosed ☐☐☐ / ☐☐

4. **Heart Attack or Angina** ☐ **Yes** ☐ No

If YES, month/year diagnosed ☐☐☐ / ☐☐

5. **Heart failure** ☐ **Yes** ☐ No

If YES, month/year diagnosed ☐☐☐ / ☐☐

6. **Peripheral vascular disease** ☐ **Yes** ☐ No

If YES, month/year diagnosed ☐☐☐ / ☐☐

7. **Needed renal replacement** ☐ **Yes** ☐ No
E.g. any form of dialysis or transplantation

If YES, month/year diagnosed ☐☐☐ / ☐☐

If so was this : ☐ **Temporary**

☐ **Permanent**

Name of the person Filling the form

Signature

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CURRENT DRUG THERAPY

What **Prescribed** medications are you taking ? ☐ **Yes (enter below)**

☐ **None**

Medication Name	Dose (if known)

COMPLETE THIS SECTION (For medications above) AFTER PATIENT VISIT USING A REFERENCE GUIDE (E.g. BNF)

Any medication for high blood pressure ? ☐ **Yes** ☐ No

If yes, (Please answer all applicable)

ACE Inhibitor	☐ **Yes**	☐ No
Angiotensin receptor blocker	☐ **Yes**	☐ No
Beta Blocker	☐ **Yes**	☐ No
Thiazide diuretic	☐ **Yes**	☐ No
Calcium channel blocker	☐ **Yes**	☐ No
Alpha-blocker	☐ **Yes**	☐ No

Are you taking hormone replacement ? ☐ **Yes** ☐ No

Are you taking an antidepressant ? ☐ **Yes** ☐ No

Are you taking regular NSAIDs ? (Regular = more than once a day for the last week) ☐ **Yes** ☐ No

LIFE STYLE ASSESSMENTS

Since we last saw you, have you changed your smoking habit? ☐ **Yes** ☐ **No**

If yes, are you a smoker or ex-smoker ? ☐ **Smoker** **Start date** ☐

☐ **Ex-smoker** **Stop date** ☐

Number of cigarettes smoked per day ? ☐ / per day

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BLOOD PRESSURE AND HEART RATE MEASUREMENTS

SEATED

		Systolic	Diastolic
Seated blood pressure	**1.**	☐☐☐	☐☐☐
	2.	☐☐☐	☐☐☐
	3.	☐☐☐	☐☐☐
	Average of last 2 readings	☐☐☐	☐☐☐

Seated heart rate (From BP monitor)	**1.**	☐☐☐
	2.	☐☐☐
	3.	☐☐☐
	Average of last 2 readings	☐☐☐

SUPINE

		Systolic	Diastolic
Supine blood pressure	**1.**	☐☐☐	☐☐☐
	2.	☐☐☐	☐☐☐
	3.	☐☐☐	☐☐☐
	Average of last 2 readings	☐☐☐	☐☐☐

Supine heart rate (From BP monitor)	**1.**	☐☐☐
	2.	☐☐☐
	3.	☐☐☐
	Average of last 2 readings	☐☐☐

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HAEMODYNAMIC MEASUREMENTS

Supine Augmentation Index

1. ☐☐☐
2. ☐☐☐
3. ☐☐☐
Average ☐☐☐

Quality Index

1. ☐☐☐
2. ☐☐☐
3. ☐☐☐
Av- ☐☐☐

Take the average of the first 2 readings if they are within 5% of each other, if not take a third reading and average the closest 2 read-

	Systolic	Diastolic
1.	☐☐☐	☐☐☐
2.	☐☐☐	☐☐☐
3.	☐☐☐	☐☐☐
Average	☐☐☐	☐☐☐

Average the same 2 readings as used above

Central (Integrated)

1. ☐☐☐
2. ☐☐☐
3. ☐☐☐
Aver- ☐☐☐

Average the same 2 readings as used above

PWV

Is a calliper being ☐ **Yes** ☐ **No**

Use the same measuring device as previous visit

Notch to carotid (mm) ☐☐☐

Notch to femoral (mm) ☐☐☐

Carotid-femoral Pulse Wave Velocity

		SD
1.	☐☐.☐	±☐.☐
2.	☐☐.☐	±☐.☐
3.	☐☐.☐	±☐.☐
Average	☐☐.☐	±☐.☐

Take the average of the first 2 readings if they are within 0.5 m/s of each other, if not take a third reading and aver-age the closest 2 read-ings

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24 h ABPM Results

ABPM MAKE/Model : Please use the same as used at Visit 1

FILL BELOW and ATTACH A PRINTOUT OF THE SUMMARY SHEET

		Systolic	Diastolic
No. of valid day-time measure-ments recorded	☐	**Mean daytime Blood pressure**	☐☐☐ ☐☐☐
		Mean daytime heart rate	☐☐☐ **BPM**
		Standard deviation daytime Blood pressure	☐☐☐.☐ ☐☐☐.☐
No. of valid night time measure-ments recorded	☐	**Mean night time Blood pressure**	☐☐☐ ☐☐☐
		Mean night time heart rate	☐☐☐ **BPM**
		STD night time Blood pres-	☐☐☐.☐ ☐☐☐.☐
		Mean 24h Blood pressure	☐☐☐ ☐☐☐
		Mean 24h heart rate	☐☐☐ **BPM**
		STD 24h Blood pressure	☐☐☐.☐ ☐☐☐.☐

Isotopic GFR

[ONLY APPLICABLE FOR DONOR PATIENTS]

Absolute iGFR (mL/min) ☐

Normal- ☐

Split iGFR

Left	Right

NOT REQUIRED

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BLOOD RESULTS

Haematology Test	Result	Units
WBC		Enter Units
Hb		Enter Units
Platelets		Enter Units

Sodium	☐☐☐	mmol/L	
Potassium	☐.☐	mmol/L	
Urea	☐☐.☐☐	mmol/L	
Creatinine	☐☐☐	umol/L	
eGFR	☐☐☐	ml/min	**eGFR: Ensure that the patient has had a meat free diet on the day of this test**
Albumin	☐☐.☐	g/L	
Calcium (corrected)	☐.☐☐	mmol/L	
Phosphate	☐.☐☐	mmol/L	

CRP			**If no value given then enter the value of the cut-off e.g. 0.003 g/L**
	Fill in the value with decimals	**Units**	

Name of the person Filling the form ☐

Signature ☐