

BLOOD PRESURE TRACKER

How often has your doctor asked you to track your blood pressure at different times of the day and to note what you were doing at the time of the blood pressure (just woke up; had argument; was sick). There are cell phone apps you can use and Primary PartnerCare Physicians will soon be providing devices at home for patients who qualify for the service. For many of us, a nice paper list works just as well. You can print copies of this sheet and place it in a 3-ring binder.

Two-Week Blood Pressure Tracker

(print multiple if your doctor wants you to track for a longer period of time)

		WEEK 1					
		Date	Time	Blood Pressure	Heart Rate	Position	Notes
S	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
M	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
T	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
W	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
T	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
F	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
S	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	

Primary PartnerCare®

WEEK 2

		Date	Time	Blood Pressure	Heart Rate	Position	Notes
S	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
M	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
T	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
W	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
T	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
F	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
S	AM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	
	PM					<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Laying Down	

TOPICS I WANT TO DISCUSS WITH MY DOCTOR ABOUT MY BLOOD PRESSURE OR THINGS I HAVE NOTICED THAT MAKE IT HIGH OR LOW:
