|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE** |  | **SYSTOLIC** | **DIASTOLIC** | **PULSE** |
| Day 1 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |
| Day 2 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |
| Day 3 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |
| Day 4 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |
| Day 5 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |
| Day 6 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |
| Day 7 | Morning 1 |  |  |  |
|  | Morning 2 |  |  |  |
|  | Evening 1 |  |  |  |
|  | Evening 2 |  |  |  |

**NAME:**

**DOB:**

**ADDRESS:**

**INSTRUCTIONS**

Please take **TWO** readings in the morning and **TWO** readings at night. Please wait **1 minute** between each reading. Do **NOT** drink caffeine containing drinks an hour or less before the readings are taken.

Please take the readings over 7 consecutive days.

**Write your reading in the table like this 140/70**

Please return this form to the Village green Surgery for action by:

* Doctor
* Nurse
* Pharmacist

The form can be returned at Nurse Reception, or via email to vgs.nursereception@nhs.net