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| |  |  | | --- | --- | |  | Home Blood pressure Monitoring |   **Please print clearly in black ink.**  First Name: Surname:  Date of Birth: NHS number (if known):  Contact No:  Please measure your blood pressure 4 times daily for as long as requested   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **DATE** | **1st Reading** | | **2nd Reading** | | **3rd Reading** | | **4th Reading** | | |  | SYS / DIA | PULSE | SYS / DIA | PULSE | SYS / DIA | PULSE | SYS / DIA | PULSE | |  | / |  | / |  | / |  | / |  | |  | / |  | / |  | / |  | / |  | |  | / |  | / |  | / |  | / |  | |  | / |  | / |  | / |  | / |  | |  | / |  | / |  | / |  | / |  | |  | / |  | / |  | / |  | / |  | |  | / |  | / |  | / |  | / |  |   Please return this form to the surgery before your medication review appointment |