Duarte-Silva D, Figueiras A, Herdeiro MT, Teixeira Rodrigues A, Silva Branco F, Polónia J, Figueiredo IV. PERSYVE - Design and validation of a questionnaire about adverse effects of antihypertensive drugs. Pharmacy Practice 2014 Apr-Jun;12(2):396 (Online supplementary material).

PERSYVE Questionnaire

Date: ___/___/___ Patient Code _____

1. Many patients have difficulties taking their medicines as the doctor recommended. In the past three months, there was any day or period of time when you did not take the drugs for blood pressure as recommended?

0□ No 1□ Yes

1.1. Because:

A. Forgetfulness	0□ No	1□ Yes
B. Economic reasons	□ No	□ Yes
C. Drugs cause discomfort or malaise	□ No	□ Yes
D. Blood pressure was normal	□ No	□ Yes
E. Blood pressure was too low	□ No	□ Yes
F. Blood pressure remained high	□ No	□ Yes
G. Other _____		

1.2. How much importance do you think it has on your blood pressure?

0□ None 1□ A little 2□ Some 3□ Many

1.3. In a month, in how many days did that happen?

0□ 1 – 6 days 1□ 7 – 12 days 2□ >12 days

2. In the last three months did you feel any of the following symptoms?

2.1. On a 1 to 5 scale, how these symptoms affect your well-being?

			Never affect	Almost never	Some times	Many times	Always affect
1Tiredness	□ No	□ Yes	1	2	3	4	5
2Feeling faint	□ No	□ Yes	1	2	3	4	5
3Sweats	□ No	□ Yes	1	2	3	4	5
4Gripes	□ No	□ Yes	1	2	3	4	5
5Nausea	□ No	□ Yes	1	2	3	4	5
6Diarrhea	□ No	□ Yes	1	2	3	4	5
7Constipation	□ No	□ Yes	1	2	3	4	5
8Palpitations	□ No	□ Yes	1	2	3	4	5
9 Swollen feet or legs	□ No	□ Yes	1	2	3	4	5
10 Cold hands or feet	□ No	□ Yes	1	2	3	4	5
11Muscle pain	□ No	□ Yes	1	2	3	4	5
12Cramps	□ No	□ Yes	1	2	3	4	5
13Headaches	□ No	□ Yes	1	2	3	4	5
14Dizziness	□ No	□ Yes	1	2	3	4	5
15Anxiety	□ No	□ Yes	1	2	3	4	5
16Sadness	□ No	□ Yes	1	2	3	4	5
17Sleep poorly	□ No	□ Yes	1	2	3	4	5
18Shortness of breath or breathing difficulty	□ No	□ Yes	1	2	3	4	5
19Persistent dry cough	□ No	□ Yes	1	2	3	4	5
20Itching	□ No	□ Yes	1	2	3	4	5
21Skin rash	□ No	□ Yes	1	2	3	4	5
22Swollen or red face	□ No	□ Yes	1	2	3	4	5
23Dry mouth	□ No	□ Yes	1	2	3	4	5
24Frequent urination	□ No	□ Yes	1	2	3	4	5
25Decreased sexual desire or ability sexual	□ No	□ Yes	1	2	3	4	5

Others symptoms: _____

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3. Have you ever spoken with someone about these symptoms?

0☐ No 1☐ Yes

If not, you did not spoke because:

1☐ Forgetfulness
2☐ Thought it was not important
3☐ Did not felt comfortable to talk about it
4☐ Thought would be misunderstood
5☐ Others _____
_____

If yes, you spoke with:

A Specialist doctor	0☐ No	1☐ Yes
B General Practitioner	☐ No	☐ Yes
C Other doctor	☐ No	☐ Yes
D Pharmacist	☐ No	☐ Yes
E Nurse	☐ No	☐ Yes
F Family/friends	☐ No	☐ Yes

4. Do you think the symptoms you have had may be caused by your medication?

0☐ No
1☐ Yes, by which?
2☐ "*I don´t know*"

	Symptom	Medications

5. Have these symptoms led you to change or stop your medicine intake?
0☐ No 1☐ Yes

6. Do you take other measures to help reduce your blood pressure?

A Exercise	0☐ No	1☐ Yes
B Diet	☐ No	☐ Yes
C Avoid salt intake	☐ No	☐ Yes
D Weight control (try not to get fat)	☐ No	☐ Yes
E Avoid stress	☐ No	☐ Yes
F Take a dietary supplement to control blood pressure	☐ No	☐ Yes