

**GUARDIAN MEDICAL CENTRE**  
Home Blood Pressure (BP) Monitoring Form

**Patient Name:** .....

**Date of Birth:** .....

**Address:** .....

DATE	TIME	SYSTOLIC BP	DIASTOLIC BP	HEART RATE	COMMENTS

Please record 14 days of home BP readings. Please vary the times you take a reading, for example do not take at the same time each day. Ensure you are sitting comfortably, legs are uncrossed, and you are not eating, drinking, or talking at the time.

It is also helpful if you record the average of your readings. To do this simply add up each column and divide by the number of readings recorded (14)

AVERAGE READING	
SYSTOLIC BP:	DIASTOLIC BP:

\*\*\* For any help or guidance please contact a member of the nursing team on 01925 650226 (option 1) \*\*\*