14 Day Recording Sheet: Self- Measured Blood Pressure Monitoring

Name:_____ Date: _____

Date	Morning			Evening		
	Time of Reading	Reading 1	Reading 2	Time of Reading	Reading 1	Reading 2
1/1/2021	8 a.m.	139/82	141/82	6 p.m.	138/81	140/81

If your blood pressure measurement is:

MORE THAN	BETWEEN	LESS THAN
____/____	____/____ & ____/____	____/____
Your blood pressure is high. Recheck in 5 minutes. If it remains in this range, call your physician immediately.	**This is the desired range for your blood pressure.** Please continue to monitor your blood pressure as you have been instructed by your care team..	**Your blood pressure is low.** Recheck in 5 minutes. If it remains in this range, call your physician immediately.

INSTRUCTIONS: If at any time you feel light headed or have a headache, check your blood pressure and call the office immediately.

Lowell Community Health Center: 978-937-9700