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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

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| **DATE** | **1st Reading** | **2nd Reading** | **3rd Reading** | **4th Reading** |
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Please return this form to the surgery before your medication review appointment  |