Have the nature and risks of this study been explained to the patient and written informed consent obtained? ☐ Yes ☐ No If 'No', do not proceed.

Date informed consent was signed: ☐☐☐☐ year ☐☐ month ☐☐ day

Inclusion criteria		
All answers must be 'YES' for the patient to be included in the study.	Yes	No
1 Patients must be males or females >=35years of age.	☐	☐
2 Duration of hypertension >=12 months		
3 Patients must be able to communicate effectively with the study personnel.	☐	☐
4 Patients must be adequately informed of the nature and risks of the study and give written informed consent prior to screening.	☐	☐
Exclusion criteria		
All answers must be 'NO' for the patient to be included in the study.	Yes	No
1 Patients with any history of alcohol abuse, illicit drug use, significant mental illness, physical dependence to any opioid in the past year, or any history of drug use or addiction in the past year.	☐	☐
2 Women who are pregnant or breast-feeding.	☐	☐
3 Inability to complete the interview	☐	☐
4Patients who, in the opinion of the Investigator, have any other medical condition which renders the patient unable to complete the study or which would interfere with optimal participation in the study or produce significant risk to the patient.	☐	☐

Was the subject included in the study? ☐ Yes ☐ No

If 'No', stop interview.

Demographics

1 Age: ☐☐ years

2 Race: ☐ Han ☐ Other, please specify_____

3 Gender: ☐ Male ☐ Female

4 Education: ☐☐ years

5 Marital status: ☐ Single ☐ Married/co-habiting ☐ Divorced/separated

☐ Widowed

6 Occupation: ☐ Farmer ☐ Driver ☐ Shop keeper ☐ Worker

☐ Education/art/community service ☐ Office occupations

☐ Unemployed ☐ Retirement

7 Smoker: ☐ Yes ☐ No

8 Alcohol use: ☐ Yes ☐ No

9 Home income: ☐ Less than 50,000yuan ☐ 50,000yuan～

10 Medical insurance: ☐ Yes ☐ No

11 How you rate your present health: ☐ Very good ☐ Good ☐ Fair

☐ Poor ☐ Very poor

Hypertension history

12 Date hypertension was diagnosed: ☐☐☐☐ / ☐☐ / ☐☐

13 Readings hypertension was diagnosed: Systolic:_____ mmHg

Diastolic:_____ mmHg

14 Hypertension type: ☐ Primary ☐ Secondary ☐ Unknown

Use of CAM, vitamin and dietary supplements				
a)Have used this kind of CAM in the last 12 months: 1=Yes 0=No **b)** The purpose for using this kind of CAM: 1 General health 2 Hypertension 3 Other conditions 4 Improve mood 5 Other reasons **c)**Information source for this kind of CAM: 1 Family/relatives 2 Friends/colleagues 3 Internet 4 Book or magazine 5 Radio or TV program 6 Doctor 7Other CAM user 8 Patients themselves **d)** Perceived effectiveness: 1 Not effective 2 A little effective 3 Effective 4 Very effective				
	a	**b**	**c**	**d**
Traditional Chinese medicine	☐	☐	☐	☐
Herbal medicine	☐	☐	☐	☐
Probiotics	☐	☐	☐	☐
Fish oil	☐	☐	☐	☐
Omega 3s	☐	☐	☐	☐
Tai chi	☐	☐	☐	☐
Qi gung	☐	☐	☐	☐
Yoga	☐	☐	☐	☐
Yangge	☐	☐	☐	☐
Relaxation	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Cupping	☐	☐	☐	☐
Spinal manipulation	☐	☐	☐	☐
Massage therapy	☐	☐	☐	☐
Prayer	☐	☐	☐	☐
Vitamin C	☐	☐	☐	☐
Vitamin B/B12	☐	☐	☐	☐
Calcium supplements	☐	☐	☐	☐
Multivitamins	☐	☐	☐	☐
Other dietary supplements	☐	☐	☐	☐

Comment log

Are there any relevant comments? ☐ Yes ☐ No

If ‘Yes’, please write down the comments below.

Comment log		
Page	Reference number	**Comments**

Principal Investigator (PI)'s Certification

	I hereby confirm that I have reviewed all of the QUESTIONNAIRE pages and that they are complete and correct to the best of my knowledge.		
Number	QC	Query issued Yes No	Name: Date: yyyy/mm/dd
	QCer:	☐ ☐	
	PI:	☐ ☐	
	QCer:	☐ ☐	
	PI:	☐ ☐	
	QCer:	☐ ☐	
	PI:	☐ ☐	
	QCer:	☐ ☐	
	PI:	☐ ☐	
	QCer:	☐ ☐	
	PI:	☐ ☐	
	QCer:	☐ ☐	
	PI:	☐ ☐	

Screen failure report

Date of visit: ☐☐☐☐ / ☐☐ / ☐☐
year / month / day

Reason for screen failure

Specify the primary reason for screen failure:

1 ☐ Failed to meet Inclusion Criteria numbers_____

2 ☐ Failed to meet Exclusion Criteria numbers_____

3 ☐ Withdrew Informed Cosent

4 ☐ Other , please specify_____

Principal Investigator Certification

I hereby confirm that I have reviewed all of the Case Report Form pages and that they are complete and correct to the best of my knowledge.

_____ _____

Signature Date(YYYY/MM/DD)

Early termination report

Did the patient complete the study? ☐ Yes ☐ No

If "**Yes**", please provide date of completion ☐☐☐☐ ☐☐ ☐☐
year month day

If "**No**", please provide date of last contact with patient ☐☐☐☐ ☐☐ ☐☐
year month day

If patient did not complete the study, please indicate the primary reason for discontinuation:_____

Principal Investigator Certification

I hereby confirm that the early termination is beyond our study ability and have done our best for the subject's best benefit.

_____ _____

Signature Date(YYYY/MM/DD)