Name:		Date of Birth:	
Please check your blood pressure when you are seated and relaxed. **Take two readings, a minute apart, and write down the lowest of the two readings.**			
		Morning	**Evening**
Day 1	**Systolic**		
	Diastolic		
Day 2	**Systolic**		
	Diastolic		
Day 3	**Systolic**		
	Diastolic		
Day 4	**Systolic**		
	Diastolic		
Day 5	**Systolic**		
	Diastolic		
Day 6	**Systolic**		
	Diastolic		
Day 7	**Systolic**		
	Diastolic		