The STOP-ACEi Trial - Participant Diary

Please complete this diary between your 3-monthly clinic assessments to record when you see a doctor, nurse or other healthcare professional because of any illness, along with any medicines prescribed, purchased by yourself, or doses of prescribed medications missed.

Hospital/Site Name:	**Trial Number:** ☐☐☐☐	**Participant Date of Birth:** MMM/YYYY
Diary given at visit number:	**Next appointment date:**	

	Date: DD/MMM/YYYY	**Date:** DD/MMM/YYYY	**Date:** DD/MMM/YYYY
Have you been seen by a doctor, nurse or other healthcare professional? *If Yes, please give details of why you were seen, by which healthcare professional and where seen e.g. GP surgery, hospital, A&E, outpatients etc.:*	No ☐ Yes ☐ If Yes, why were you seen? If Yes, who were you seen by? If Yes, where were you seen?	No ☐ Yes ☐ If Yes, why were you seen? If Yes, who were you seen by? Where were you seen?	No ☐ Yes ☐ If Yes, why were you seen? If Yes, who were you seen by? Where were you seen?
Have you been prescribed any new medicines or changed your existing medication? *If Yes, please give details:*	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Have you bought any medicines over the counter for yourself (i.e. without a prescription)? *If Yes, please give details:*	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Any other problems? *If Yes, please give details:*	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐

The STOP-ACEi Trial - Participant Diary

Please complete this diary between your 3-monthly clinic assessments to record when you see a doctor, nurse or other healthcare professional because of any illness, along with any medicines prescribed, purchased by yourself, or doses of prescribed medications missed.

Hospital/Site Name:	**Trial Number:** ☐☐☐☐	**Participant Date of Birth:** MMM/YYYY
Diary given at visit number:	**Next appointment date:**	

	Date: DD/MMM/YYYY	**Date:** DD/MMM/YYYY	**Date:** DD/MMM/YYYY
Have you been seen by a doctor, nurse or other healthcare professional? *If Yes, please give details of why you were seen, by which healthcare professional and where seen e.g. GP surgery, hospital, A&E, outpatients etc.:*	No ☐ Yes ☐ If Yes, why were you seen? If Yes, who were you seen by? If Yes, where were you seen?	No ☐ Yes ☐ If Yes, why were you seen? If Yes, who were you seen by? Where were you seen?	No ☐ Yes ☐ If Yes, why were you seen? If Yes, who were you seen by? Where were you seen?
Have you been prescribed any new medicines or changed your existing medication? *If Yes, please give details:*	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Have you bought any medicines over the counter for yourself (i.e. without a prescription)? *If Yes, please give details:*	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Any other problems? *If Yes, please give details:*	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐