

## High Blood Pressure and Build Questionnaire

Name \_\_\_\_\_  Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Tobacco Use:  No  Cigarettes  Other tobacco \_\_\_\_\_ Date quit? \_\_\_\_\_

State \_\_\_\_\_ Amount of Insurance \_\_\_\_\_ Type of Insurance \_\_\_\_\_

Occupation/Source of income: \_\_\_\_\_

1. Date high blood pressure/ hypertension was diagnosed: \_\_\_\_\_

2. How often do you visit your physician? \_\_\_\_\_

3. High Blood Pressure is controlled by:  Diet and exercise alone \_\_\_\_\_

Medication- type and amount of medication: \_\_\_\_\_

4. Test Results: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Cholesterol: \_\_\_\_\_

HDL: \_\_\_\_\_

LDL: \_\_\_\_\_

5. Other medications: \_\_\_\_\_

6. Do you have any of the following complications:  chest pain,  diabetes,  elevated cholesterol,  stroke or TIA (Transient Ischemic Attack),  kidney disease,  peripheral vascular disease,  coronary artery disease or other heart problems,  abnormal EKG,  abnormal Stress EKG.

Details #6: \_\_\_\_\_

### General Questions

1. Do you have any other major health problems?  No  Yes– Details: \_\_\_\_\_

2. List all medications: \_\_\_\_\_

3. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Most recent blood pressure reading: \_\_\_\_\_

Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

