

## Hypertension Evaluation Sheet

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Smoking history Yes \_\_\_\_\_ No \_\_\_\_\_

Medical History:

\_\_\_\_\_

Family Medical History:

\_\_\_\_\_

|             | <u>Age</u> | <u>Current Health</u> | <u>Cause/Age of Death</u> |
|-------------|------------|-----------------------|---------------------------|
| Father      | _____      | _____                 | _____                     |
| Mother      | _____      | _____                 | _____                     |
| Brother (s) | _____      | _____                 | _____                     |
| Sister (s)  | _____      | _____                 | _____                     |

Coronary Risk Factors:

\_\_\_\_\_

Blood Pressure Readings (all three must be completed)

Date \_\_\_\_\_ B/P \_\_\_\_\_/\_\_\_\_\_ Where taken \_\_\_\_\_

Date \_\_\_\_\_ B/P \_\_\_\_\_/\_\_\_\_\_ Where taken \_\_\_\_\_

Date \_\_\_\_\_ B/P \_\_\_\_\_/\_\_\_\_\_ Where taken \_\_\_\_\_

Date of Resting ECG \_\_\_\_\_ (please submit with this form)

If Stress Test done, please indicate date done here \_\_\_\_\_

Labs: FBS \_\_\_\_\_ Tot. Cholesterol \_\_\_\_\_ LDL \_\_\_\_\_  
HDL \_\_\_\_\_ Triglycerides \_\_\_\_\_ Creatinine \_\_\_\_\_  
Potassium \_\_\_\_\_

Current Medications:

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Any Medication Side Effects? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what? \_\_\_\_\_

Treating Physician:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/Zip Code \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_