

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 _____ PM _____/_____

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 Cardiovascular or other symptoms or medication Side Effects? Yes _____ No _____

If so, what? _____

Treating Physician:

Name _____

Address _____

City/Zip Code _____

Signature of Physician _____ Date _____

Form created by Gordon Ritter, D.O. , revised Gregory Pinnell, MD 4/07, updated by Robert J. Gordon, D.O. 2-2011

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