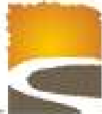

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HYPERTENSION HISTORY

Please bring old records including laboratory and procedures

Today's date: _______________Date of Diagnosis: __________________

Name: ____

Address: ____

City: __________________________State: __________ Zip: ___________

Birth Date: _____________________ Age: ___________ Gender: _______

Home phone: ____________________ Work Phone: __________________

E Mail: ____

Source of referral: Self referred Physician/Provider Other

Referring/Primary Care Provider and telephone number:

____

Family Heritage (Circle all that apply):

White American Indian/Alaska Native Black/African American

Asian Native Hawaiian/Pacific Islander Spanish/Latino/Hispanic

Occupation: ______________________Hours worked per week:__________

Do you have any of the following health concerns?

Heart disease

Difficulty with sexual function

Eye or vision problems

Heart disease

Numbness/pain in extremity

Diabetes

Circulation problems

Stroke

Date of last eye exam: ___________Date of last dental exam:__________

Eye doctor: ______________________ Dentist: ________________________

Diet: Briefly describe your diet

____

____

____

____

Exercise: What type of exercise do you perform and how often?

____

____

____

Has your weight changed in the past year? Yes No How much?

____

Do you use alcohol? No Yes
How much and how often? ____

Do you use or have you ever used tobacco products? ____________________
When did you quit? ____

What hobbies bring enjoyment to your life?

____

Describe your overall health____
____
____

Please circle the disease state if you have a family history of:

Diabetes	If yes, whom? ______________________________
Thyroid disease	If yes, whom? ______________________________
Heart disease	If yes, whom? ______________________________
High cholesterol	If yes, whom? ______________________________
Kidney failure	If yes, whom? ______________________________
Cancer	If yes whom and what type?___________________
	____
Other family illnesses	____
	____
	____

What type of medical problems or surgeries have you had in the past?

Diagnosis/Date

____
____
____
____
____
____
____

Medications

Please all of your medications, *prescription and OTC*

Name	Dose	Frequency	Doctor

Do you have any drug allergies or intolerances? What type of reactions did you experience?

____
____

High Blood Pressure Treatment

When where you first diagnosed with hypertension?

___

Do you have a home blood pressure monitor? What brand name and when did you purchase it? ___

Is there a family history of hypertension? If yes, whom?

___

___

Have any family members experienced heart attacks, strokes, non traumatic amputations younger than 60 years or age?

___

What high blood pressure medications have been tried in the past? Why were they discontinued or changed?___

___

What type of vascular/circulation problems have you experienced in the past and what type of treatment was rendered?

___

___

Do you experience pain in your legs which is relieved by rest? How long do your symptoms last and when do you begin having these symptoms?

___

Do you have a history of "mini stokes" or strokes?

___

Have you ever had an exercise stress test? Who performed it, where, and when?

___

Have you ever undergone a heart catheterization (dye injected into heart arteries)? Who performed it, where, and when?

Have you ever had an ultrasound (Doppler) of your carotid arteries? Where?

What are health care goals and how can we facilitate those goals?

____

____

Patient signature: ________________________________Date:___________

Reviewed by: ___________________________________Date:___________