

Hypertension Evaluation Worksheet

Patient's Name _____ Date _____

Age _____ Weight _____ Height _____ Blood Pressure Today _____

Smoking History _____ or Non-smoker _____

Personal Medical History: _____

Family Medical History _____

Age	Health	Cause of Death
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Father _____

Mother _____

Brother _____

Sister _____

Coronary Risk Factors: _____

Blood Pressure History

#1 ____/____/____ Date ____/____/____ Location: _____

#2 ____/____/____ Date ____/____/____ Location: _____

#3 ____/____/____ Date ____/____/____ Location: _____

ECG (resting): _____ ECG Stress Test (if indicated): _____

Fasting Plasma Glucose: _____ Total Cholesterol: _____ LDL: ____ HDL: ____

Triglycerides: _____ Creatinine: _____ Potassium: _____

MEDICATIONS USAGE:

Rx _____ Dosage: _____ Frequency: _____

Rx _____ Dosage: _____ Frequency: _____

Rx _____ Dosage: _____ Frequency: _____

Presence/Absence/History of adverse side effects: _____

Signature of Treating Physician _____