

**Hypertension Evaluation Worksheet**

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

Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Smoking History: \_\_\_\_\_ Non-smoker: \_\_\_\_\_

Personal Medical History:

\_\_\_\_\_  
\_\_\_\_\_

Family Medical History:

\_\_\_\_\_  
\_\_\_\_\_

	Age	Health	Cause of Death
Father:	_____	_____	_____

Mother:	_____	_____	_____
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Siblings:	_____	_____	_____
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**Coronary Risk Factors:**

\_\_\_\_\_

**Blood Pressure Readings:**

#1 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reading: \_\_\_\_\_

#2 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reading: \_\_\_\_\_

#3 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reading: \_\_\_\_\_

ECG: \_\_\_\_\_ Stress Test (if indicated): \_\_\_\_\_

**Lab work:** Date: \_\_\_\_\_

Fasting Glucose: \_\_\_\_\_ Total Cholesterol: \_\_\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_

Triglycerides: \_\_\_\_\_ Creatinine: \_\_\_\_\_ Potassium: \_\_\_\_\_

**Medications:**

Rx: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Rx: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Presence/Absence/History of adverse side effects:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_