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:			
Siblings:			

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: _____