

Hypertension Evaluation Worksheet

Name _____ Date _____

Age _____ Weight _____ Height _____ Blood Pressure _____

Smoking History _____ or Non-smoker _____

Personal Medical History: _____

Family Medical History _____

	Age	Health	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____

Coronary Risk Factors: _____

Blood Pressure

#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: _____

Presence/Absence/History of adverse side effects: _____

Signature _____