Hypertension Evaluation Sheet

Patient Name ________________________________ DOB ____________
Age _________ Height ________ Weight ________
Smoking history Yes _____ No _____
Medical History:

____

____

Family Medical History:

____

____

	Age	Current Health	Cause/Age of Death
Father			
Mother			
Brother (s)			
Sister (s)			

Coronary Risk Factors:

____

____

Blood Pressure Readings (all three must be completed)
Date __________ B/P _____/_____ Where taken ____________________
Date __________ B/P _____/_____ Where taken ____________________
Date __________ B/P _____/_____ Where taken ____________________

Date of Resting ECG ________ (please submit with this form)
If Stress Test done, please indicate date done here __________

Labs: FBS __________ Tot. Cholesterol __________ LDL __________
HDL __________ Triglycerides __________ Creatinine ________
Potassium __________ DATE OF LABS ______________

Current Medications:
Rx ____________________ Dosage __________ Sig __________
Rx ____________________ Dosage __________ Sig __________
Rx ____________________ Dosage __________ Sig __________
Rx ____________________ Dosage __________ Sig __________

Any Medication Side Effects? Yes ____ No ____
If so, what? ____

Treating Physician:
Name ____
Address ______________________________________
City/Zip Code _________________________________

Signature of Physician ________________________________ Date _________

Form created by Gordon Ritter, D.O. , revised Gregory Pinnell, MD 4/07