HYPERTENSION

Client name: _____

DOB: _____ Height: _____ Weight: _____

1. Date of diagnosis: _____

2. What was the most recent blood pressure reading? _____ Date: _____

3. List all medication(s) client is taking? (name, dosage, start date and reason for taking)

4. Please check any health issues that client has had:

☐ chest pain or coronary artery disease	☐ aneurysm
☐ diabetes	☐ peripheral vascular disease
☐ abnormal lipid levels	☐ kidney disease
☐ TIA or stroke	☐ overweight
☐ enlarged heart	☐ family history (parent/sibling): heart disease, cancer, high blood pressure, stroke, diabetes

5. Check any tests that have been completed within the past year, and results.

☐ EKG	☐ normal	☐ abnormal
☐ stress electrocardiogram (treadmill test)	☐ normal	☐ abnormal
☐ echocardiogram	☐ normal	☐ abnormal

6. List any other health issues—diagnosis & date. (Additional questionnaires may be required.)

Please submit the *Client Information Questionnaire* with this form

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