HYPERTENSION SCREENING FORM

Date: ___/___/___

Name: _____

Address: _____

_____

Phone #: _____- _____-_____

Sex: M _____ F _____ DOB: ___/___/___

Race: White _____ Black _____ Hispanic _____ OTHER_____

1. Have you ever been told by a physician that you have high blood pressure?

   YES_____NO____

2. Are you now under treatment for high blood pressure?

   YES____NO____

3. What type of treatment?

   Diet _____Salt Restriction _____ Medication _____ OTHER_____

   If you are on medication(s), which one(s)? _____

   _____

4. Do any of your blood relatives have high blood pressure?

   YES____NO____

5. Do you smoke? YES____NO____

*BLOOD PRESSURE _____ L R

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***REFER TO PROVIDER IF BLOOD PRESSURE IS GREATER THAN 140/90.**

Referred to Provider: YES_____NO_____

NURSE SIGNATURE: _____

12/01/2010dam