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
*BLOOD PRESSURE ______________________ L   R

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

Referred to Provider: YES____NO____

NURSE SIGNATURE: ________________________________

12/01/2010dam