

Hypertension History Check List

Patient Name: _____

Medical Record Number: _____

The patient is:

- Male
 Female

Patient age is: _____

Medical History

1. "Have you ever had a heart attack or stroke?" Yes
 No
 Not sure
2. "Do you get chest pain when you exert (exercise, work, or hurry) yourself?" Yes
 No
3. "Do you have leg muscle tightness or fatigue when you walk or climb a flight of stairs?" Yes
 No
4. "Do you have kidney disease or have been told you have protein in your urine?" Yes
 No
 Not sure
5. "Have you ever been told by a doctor that you have diabetes?" Yes
 No
 Not sure
6. "Do you currently smoke?" Yes
 No
7. If you smoke, have you been advised by a doctor to stop?" Yes
 No

8. "Has your cholesterol been tested within the past 5 years?"

Yes
 No
 Not
sure

9. "Do you have high LDL (or bad) cholesterol or take medications for high LDL (or bad) cholesterol?"

Yes
 No
 Not
sure

10. "Has your blood pressure been taken by a doctor or someone in the doctor's office in the past year?"

Yes
 No
 Not
sure

11. "Do you check your blood pressure at home?"

Yes
 No

12. "Has your doctor or someone from the office given you information on the effects of high blood pressure on the kidneys?"

Yes
 No
 Not
sure

13. "Has your doctor or someone from the office given you information about the side effects of your medications?"

Yes
 No
 Not
sure

14. "Has your doctor or someone from the office asked you about side effects of your medications?"

Yes
 No
 Not
sure

15. "During a typical week, how many days do you get a total of at least 30 minutes of physical activity that raises your heart rate?"

- 1
- 2
- 3
- 4
- 5
- 6
- 7

Family History

16. "Do you have a brother or father with heart disease diagnosed before age 55 years?"

- Yes
- No
- Not sure

17. "Do you have a sister or mother with heart disease diagnosed before age 65 years?"

- Yes
- No
- Not sure

Social History

18. "Many people find it hard to follow a doctor's advice or take all their medications. Do you find this difficult too?"

- Yes
- No

19. "Some people have trouble affording their medications or getting to their appointments. Do you find this difficult too?"

- Yes
- No

20. "Some people have other medical problems that make it difficult to do all the right things to keep healthy, such as eating a healthy diet and exercising regularly. Has this been a problem for you too?"

- Yes
- No

21. "Some people have emotional or mental health problems that make it difficult to follow the doctor's recommendations or take their medications. Has this been a problem for you?"

- Yes
- No

Dietary History

22. "How many servings of fruits and vegetables do you eat in a typical day?"

- 1
- 2
- 3
- 4

23. "Are you currently on a low salt (sodium restricted) diet?"

- Yes
- No
- Not sure

24. "Are you currently on a low fat (low cholesterol) diet?"

- Yes
- No
- Not sure

25. "Do you (or whoever buys your groceries) read the nutrition facts label on food items to decide whether or not to buy them?"

- Yes
- No
- Not sure