HYPERTENSION

CHRONIC DISEASE MANAGEMENT FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number : **Gender** : ☐ Male ☐ Female

MEDICAL HISTORY

Do you have a diagnosis of hypertension, high blood pressure, or elevated blood pressure?

☐ Yes

☐ No

If yes, how long have you been diagnosed?
What is your last recorded blood pressure?

Do you have an immediate family member with a history of hypertension? ☐ Yes ☐ No

SYMPTOMS AND BLOOD PRESSURE READINGS

Do you experience occasional headaches, vision changes, shortness of breath, hand or leg swelling, numbness, or muscle weakness? ☐ Yes ☐ No

Do you monitor your blood pressure at home? ☐ Yes ☐ No

If yes, do you get readings of 140/90 mm HG or higher? ☐ Yes ☐ No

CURRENT MEDICATIONS

Are you currently taking any prescription or nonprescription medicines to lower your blood pressure? ☐ Yes ☐ No

List medications taken for high blood pressure.

THANK YOU FOR YOUR INFORMATION