

HYPERTENSION QUESTIONNAIRE (Answer all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated / relationship to applicant: _____

1. Date high blood pressure first diagnosed? _____ Blood pressure reading at that time? _____

2. Are you taking medication(s) for your blood pressure? ___ Yes ___ No

a. **Name of Medication:** _____ **Dosage:** _____ **Frequency (ie.,daily,as needed)**

b. If no, did you doctor recommend discontinuation? ___ Yes ___ No Date Discontinued: _____

3. How often do you see your doctor for blood pressure checkups? _____

4. Please provide last **5 blood pressure readings from your doctor** and **date of readings**:

If you monitor your blood pressure at home, what does it normally run? _____

5. What is your current height? _____ and weight? _____

6. Any history of: **(Circle one)**

Circulatory Disorder	Yes	No
Kidney disease	Yes	No
Diabetes	Yes	No
Heart disorder / murmurs	Yes	No
Cerebrovascular disease (Stroke, TIA)	Yes	No
Valve problems or enlarged heart	Yes	No

Please explain any "yes" answers: _____

7. Do you know your cholesterol reading? ___ Yes ___ No (If yes, please list latest reading) _____

Medication required? ___ Yes ___ No

Name of Medication: _____ Dosage: _____ Frequency: _____

8. Have you ever been hospitalized for your high blood pressure? ___ Yes ___ No

(If yes, name and address of hospital? _____

Date of hospitalization and treatment _____

9. Name and address of treating physician: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date