

## Hypertension Questionnaire ©

Name \_\_\_\_\_

Date \_\_\_\_\_

rev 8/09

I do/do not take my own blood pressure at home (circle which). How often?	Yes / No
I have had ambulatory blood pressure monitoring done.	Yes / No
My highest blood pressure ever without treatment was (write it here).	
My lowest blood pressure ever without treatment was (write I there).	
My blood pressure is about _____ / _____ not on medication.	
My blood pressure is about _____ / _____ while on medication.	
I have experienced a stroke or Transient Ischemic Attack ("TIA").	Yes / No
I have cardiovascular disease or congestive heart failure.	Yes / No
I have been told my heart is enlarged.	Yes /No
I have a family history of hypertension or stroke on my mother's or father's side (circle one or both).	Yes / No
I am a diabetic, pre-diabetic or have elevated blood sugar.	Yes / No
I bruise easily or have been told I have vascular hypertension.	Yes / No
I have renal hypertension or poor kidney function, or I am on a diuretic (water pill) or I hold fluid easily (circle all that apply).	Yes / No
I exercise a lot or sweat a lot at work.	Yes / No
I have a tendency to be anxious or have experienced anxiety or panic attacks in the past.	Yes / No
I am often tired or sometimes get lightheaded when standing suddenly, or have been told I have weak adrenals / adrenal fatigue, or I am under a lot of stress.	Yes / No
I have had an endocrinology consultation and tests ordered by him/her.	Yes / No
I have been diagnosed with "resistant" or "renovascular" hypertension.	Yes / No
I have had cardiac catheterization for this problem.	Yes / No
I have had a serum renin/aldosterone/hormone blood tests done (circle which).	Yes / No
I have had a hsCRP done or a ADMA (asymmetric dimethylarginine) level done (circle which).	Yes / No
What hypertension / cardiovascular medications are you taking?  a. _____ how long _____ b. _____ how long _____ c. _____ how long _____ d. _____ how long _____ e. _____ how long _____	
What were you prescribed in the past that was discontinued for one reason or another? a. _____ how long _____ b. _____ how long _____ c. _____ how long _____ Why were they stopped? Give side effects, if any _____ _____	
What supplements are you currently taking for hypertension / cardiovascular health?  a. _____ how long _____ b. _____ how long _____ c. _____ how long _____ d. _____ how long _____ e. _____ how long _____ f. _____ how long _____	
Have you used behavior modification techniques? Which? _____ times/week _____	Yes / No
Have you used a RESPeRATE or other? if yes, write in here _____ Times/day used? _____	_____ times
Have you been considered for an implantable Rheos blood pressure lowering "pacemaker"?	Yes / No

Anything else you feel is important? \_\_\_\_\_