Supplemental History Sheet for Hypertension Patients

Patient Name Date:

General	**Yes**	**No**
Does anyone in your family have high blood pressure?	❍	❍
How long have you had high blood pressure?	❍	❍
Do you take over the counter pain pills?	❍	❍
Have you had any changes in your urine output in the last year?	❍	❍
Do you take Oral Contraceptive Pills or hormone replacement pills?	❍	❍
Have you had any weight changes over the last year?	❍	❍
Dietary		
Any recent changes to your diet?	❍	❍
Do you eat a lot of salt?	❍	❍
Do you drink more than one alcoholic beverage per day?	❍	❍
Do you consume caffeine, i.e. coffee, tea, coke or other soft drinks?	❍	❍
Renal Artery Stenosis		
Has your blood pressure become worse in the last six months?	❍	❍
Did you have high blood pressure before the age of 30?	❍	❍
Did your high blood pressure start suddenly?	❍	❍
Do you have episodes of sudden shortness of breath?	❍	❍
Sleep Apnea		
Do you sleep well?	❍	❍
Do you snore at night?	❍	❍
Are you sleepy during the day?	❍	❍
CRF/Glomerulonephritis		
Have you ever had blood in urine?	❍	❍
Any New Rashes?	❍	❍
New Joint Pains?	❍	❍
Fever or chills?	❍	❍
Muscle cramps?	❍	❍
Endocrine/Pheochromocytoma		
Do you have Feelings of anxiety or doom?	❍	❍
Do you have high blood pressure “spells”?	❍	❍
Do you feel cold or hot easily?	❍	❍