

**HYPERTENSION EVALUATION WORKSHEET**  
**for single diagnosis (HTN without other metabolic disorders)**

**Airmen Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Blood Pressure:** \_\_\_\_/\_\_\_\_

**Does the airman have symptoms as a result of hypertension?** \_\_\_\_\_

**Blood Pressure Medications**

**Rx** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Frequency** \_\_\_\_\_

**Rx** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Frequency** \_\_\_\_\_

**Rx** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Frequency** \_\_\_\_\_

**PLEASE also list all other medications and dosages the airman is taking:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Does the airman have any side effects from these medications?** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Medical Professional**

\_\_\_\_\_  
**Printed Name of Medical Professional**

**Address of Practice:** \_\_\_\_\_

\_\_\_\_\_

**Phone Number:** \_\_\_\_\_