

INITIAL HYPERTENSION EVALUATION WORKSHEET

Airmen Name: _____

Date of Birth: _____

Date: _____

Age: _____ Weight: _____ Height: _____ Blood Pressure: ____/____

Smoking History: _____ or Non Smoker

Personal Medical History: _____

Family Medical History: _____

Coronary Risk Factors: (Yes or No): _____

Blood Pressure

#1 Date _____ Reading: ____/____ Location: _____

#2 Date _____ Reading: ____/____ Location: _____

#3 Date _____ Reading: ____/____ Location: _____

EKG (resting) - INCLUDE ORIGINAL OR GOOD COPY: _____

Exercise Stress Test (only if indicated) _____

Labs:

Date: _____ Fasting Plasma Gluc: _____ T- Cholesterol _____ LDL _____

HDL _____ Triglycerides _____ Creatinine _____ Potassium _____

Medication Usage:

Rx _____ Dosage _____ Frequency _____

Rx _____ Dosage _____ Frequency _____

Rx _____ Dosage _____ Frequency _____

Presence or Absence of adverse side effects: _____

Signature of Medical Professional

Printed Name of Medical Professional

Address of Practice: _____

Phone Number: _____