



# 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

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