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Questionnaire for Suspected Hypertension and/or Need for Antihypertensive Medication

Print and fill out this questionnaire. Take it to your primary care provider to discuss high blood pressure.

1. Have you been treated for hypertension in the past?_____
   If yes: What treatment did you receive and why was it stopped? _____
   _____
2. Do you drink alcohol? _____
   If yes: What type, how often per week and how much?_____
   _____
3. What does your physical activity look like (what kind, how often per week, how long per session)? _____
   _____
   _____
4. Do you season your food with salty spice blends?_____
5. Do you add salt to your meals when eating out? _____
6. Do you have erectile dysfunction?_____
7. Do you take any medication (including over-the-counter, herbal remedies, dietary supplements, vitamins)? _____
   If yes: Which ones, which dosage and how often? _____
   _____
   _____
   _____
8. Do/Did you have any relatives (parents, siblings, children) with the following diseases?
   If yes: Who and at what age was he/she diagnosed?
   a. High blood pressure_____
   b. Diabetes mellitus _____
   c. High cholesterol _____
   d. Heart attack _____
   e. Stroke _____

9. Does at least one of the following apply to you? _____
    a. I am younger than 40 years old.
    b. My blood pressure has increased suddenly.
    c. I suffer from extremely high blood pressure values (systolic from 175mmHg and/or diastolic from 105mmHg).
    d. My blood pressure cannot be adequately lowered even though I already take medication to treat it.
10. Does at least one of the following apply to you? _____
    a. I sometimes suddenly become pale, start sweating, get palpitations and headaches.
    b. Someone in my family has a pheochromocytoma (tumor of the adrenal gland).
    c. I often feel hot, lose weight easily, tremble often and have heart palpitations.
    d. I have been told that I snore loudly. I also tend to fall asleep during the day.