

PATIENT HISTORY
 IN PREPARATION FOR YOUR APPOINTMENT WITH THE
HYPERTENSION CLINIC, UT SOUTHWESTERN MEDICAL CENTER AT DALLAS

NAME _____ DR MR MS MRS

DATE OF BIRTH _____ SSN _____ UTSW MRN _____

MARITAL STATUS Single Married Widowed Divorced PPHS MRN _____

REQUESTED PROVIDER (DOCTOR) IN THE HYPERTENSION CLINIC _____ ACCOUNT # _____

VISIT DATE _____ CHIEF COMPLAINT _____

HOME ADDRESS _____ WORK ADDRESS _____

PHONE WORK _____ HOME _____ MOBILE _____

RACE Caucasian East Indian Male Female IS THIS VISIT FOR CLINIC OR RESEARCH PURPOSES?
 Black Pacific Islander Female Clinic
 Hispanic Alaskan Native Research
 American Indian Don't Know Don't Know
 Asian Refuse to Answer

BIRTH COUNTRY _____

MOTHER'S RACE Caucasian East Indian FATHER'S RACE Caucasian East Indian
 Black Pacific Islander Black Pacific Islander
 Hispanic Alaskan Native Hispanic Alaskan Native
 American Indian Don't Know American Indian Don't Know
 Asian Refuse to Answer Asian Refuse to Answer

MOTHER'S BIRTH COUNTRY _____

FATHER'S BIRTH COUNTRY _____

PRIMARY CARE PHYSICIAN (PCP) _____ MD DO

PCP ADDRESS _____ PHONE _____

_____ FAX _____

WHO WOULD YOU LIKE US TO CONTACT IN CASE OF EMERGENCY?

NAME _____ RELATION _____

PHONE WORK _____ HOME _____ MOBILE _____

HISTORY OF HIGH BLOOD PRESSURE (HYPERTENSION)

Have you ever been hospitalized for high blood pressure? Y N
 If Yes, how many times? _____ Date of last hospitalization for high blood pressure _____

Have you ever made a visit to the Emergency Room? Y N
 If Yes, how many times? _____ Date of last visit to the Emergency Room _____

What was your last known blood pressure reading? _____ / _____ Date this reading was taken? _____

Who took this reading? Self Nurse Doctor

Do you take your own blood pressure? Y N

How often is your blood pressure taken?
 Never Weekly Monthly 3 times a week More than 6 months
 Daily Monthly 1 time a week Every 3 months

What type of home blood pressure cuff do you use?
 None Standard Manual Wrist device
 Automatic Finger

Have you been trained how to use this cuff?
 Y N DON'T KNOW

Have you received any dietary education?
 Do you read sodium labels on your food?
 Do you keep track of your salt intake?
 Do you eat a low fat diet?

Y N DON'T KNOW

MEDICAL HISTORY

Have you ever been diagnosed with any of the following? Check yes or no.

HEART ATTACK Y N
 If yes, when? _____

STROKE Y N
 If yes, when? _____
 Type Aneurysm Hemorrhagic
 Thrombotic Unknown

CANCER Y N
 Type(s) _____

HYPERLIPIDEMIA Y N
 High total cholesterol
 High triglycerides
 Low HDL (good cholesterol)
 High LDL (bad cholesterol)

KIDNEY DISEASE Y N
 Renal Insufficiency
 Kidney Dialysis
 Kidney Transplant
 Nephrotic Syndrome
 Polycystic Kidney

Atrial Fibrillation Y N DON'T KNOW
Heart Failure
Coronary Bypass
Angioplasty/stent
Pacemaker
Defibrillator/ICD

HEART VALVE SURGERY Y N
 Aortic
 Mitral
 Tricuspid

CARDIAC ARREST Y N DON'T KNOW
ASTHMA
CHRONIC OBSTRUCTIVE LUNG DISEASE
DIABETES

HYPERTHYROID Y N DON'T KNOW
HYPOTHYROID
SLEEP APNEA
POLYCYSTIC OVARIES

OTHER SURGERY Y N
 If yes, list type and date of surgery _____

SOCIAL HISTORY

Please indicate if any of the following apply to you. Check yes or no.

ALCOHOL INTAKE # Drinks/Day Y N Wine Beer Hard Liquor Y N Cocaine Use Marijuana Use Heroin

TOBACCO USE Y N
 Cigarettes _____ packs/day
 Cigars _____ cigars/day
 Chew _____ dips/day
 If yes, # years used _____

EXERCISE Y N
 Walking Swimming Aerobics Martial Arts
 Running Bicycling Weight-lifting Other

FREQUENCY Daily 3 Months 1 x week
 Weekly 6 Months 2 x week
 Monthly 3 x week

TIME/DAY <30 Minutes 2 Hours
 1 Hour < 2 Hours

EMPLOYER _____ OCCUPATION _____
 ADDRESS _____ NAME OF SUPERVISOR _____
 SELF EMPLOYED? Y N
 RETIRED? Y N

FAMILY HISTORY Have any family members been diagnosed with the following? Answer Yes/No. If Yes, please provide age of death if applicable.

	Hypertension	Heart Attack	Stroke	Kidney Disease	Diabetes	Deceased
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____	_____
Sister #1	_____	_____	_____	_____	_____	_____
Sister #2	_____	_____	_____	_____	_____	_____
Sister #3	_____	_____	_____	_____	_____	_____
Brother #1	_____	_____	_____	_____	_____	_____
Brother #2	_____	_____	_____	_____	_____	_____
Brother #3	_____	_____	_____	_____	_____	_____
Daughter #1	_____	_____	_____	_____	_____	_____
Daughter #2	_____	_____	_____	_____	_____	_____
Daughter #3	_____	_____	_____	_____	_____	_____
Son #1	_____	_____	_____	_____	_____	_____
Son #2	_____	_____	_____	_____	_____	_____
Son #3	_____	_____	_____	_____	_____	_____

REVIEW OF SYMPTOMS

Fatigue with activity?

Y N DON'T KNOW

Short of breath on lying?

Y N DON'T KNOW

Do you snore?

Y N DON'T KNOW

How many HIGH blood pressure episodes have you had? _____

How many LOW blood pressure episodes have you had? _____

How often do you experience the following? NEVER DAILY WEEKLY MONTHLY

Heart palpitations _____ _____ _____ _____

Flushing _____ _____ _____ _____

Chest pain _____ _____ _____ _____

Cough _____ _____ _____ _____

Fever _____ _____ _____ _____

Constipation _____ _____ _____ _____

Diarrhea _____ _____ _____ _____

Headaches _____ _____ _____ _____

Blurred vision _____ _____ _____ _____

Muscle cramps / pain _____ _____ _____ _____

Weakness _____ _____ _____ _____

Dizziness _____ _____ _____ _____

Pallor _____ _____ _____ _____

Nausea / vomiting _____ _____ _____ _____

Excessive sweat _____ _____ _____ _____

Shortness of breath _____ _____ _____ _____

Swelling in ankles _____ _____ _____ _____

Abdominal pain _____ _____ _____ _____

Sexual dysfunction _____ _____ _____ _____

Urinary Tract Infection _____ _____ _____ _____

