

High Blood Pressure Questionnaire

Community **HealthFirst**[™]
Medicare Advantage Plans



Name: _____

Date Completed: _____

Member #: _____

Date of Birth: _____

Thank you for taking the time to complete this questionnaire. Your answers are important and will help us to meet your health care needs. This questionnaire will take about 10 minutes to finish

General Information

1. What is your address and best contact telephone number?
_____ (Address) (City, State, Zip code) () _____ (Phone number)
2. What is your primary language? Do you need an interpreter? Yes No Don't know
3. What is the name of the doctor or care provider you see most? _____
Clinic Name/Address: _____ Phone: () _____

General Health Information

4. Have you had a flu shot? Yes No Don't know
If yes, what was the date of your last flu shot? _____
5. Have you had a pneumonia shot? Yes No Don't know
If yes, what was the date of your last pneumonia shot? _____
6. Are there any other medical problems you are being treated for? Yes No Don't know
If yes, please explain: _____

7. In the last 6 months, have you been to the emergency room (ER) for high blood pressure? If yes, how many times? Yes No Don't know

8. What are your health goals and interests? Eating better Reducing stress Losing weight
 Exercising Aging well Other

Medication Information

9. What prescription medications do you take?
Please list: _____

10. Do you take non-prescription medications or supplements (for example, aspirin, vitamins, etc.)? If yes, please list: Yes No Don't know

11. Have you been taking your medications as prescribed by your doctor? Yes No Don't know
If no, why not? _____
12. Are you having any problems taking your medications? Yes No Don't know
If yes, please explain: _____

High Blood Pressure Questionnaire

High Blood Pressure Information

13. Has your doctor told you that you have High Blood Pressure? Yes No Don't know
14. How often do you see your doctor for blood pressure checkups?
 monthly
 every 3-4 Months
 every 6 months
 once a year
15. What was your last systolic blood pressure reading? (top number) _____ Don't know
16. Your last diastolic blood pressure reading? (bottom number) _____ Don't know
17. Have you had a blood pressure reading of 140/90 or less in the last year? Yes No Don't know
18. Do you take your blood pressure at home? Yes No Don't know
 What was the last reading? _____ Date : _____
19. Which of the following symptoms have you had?
 Blurry Vision
 Chest Pain
 Dizziness
 Headaches
 None
 Other _____
20. Does high blood pressure affect the ability to perform your usual daily activities? If yes, how? _____ Yes No Don't know
21. Select the type of diet you are following. Yes No Don't know
 Diabetic
 Low Carbohydrate / Sugar
 Low Cholesterol
 Low Salt
 Renal (Low Protein/Low Salt)
 Weight Reduction
 Vegetarian
 No Special Diet
22. Have you been told you have high cholesterol? Yes No Don't know
 If yes, have you seen a nutritionist? _____
23. What was your last LDL (bad) cholesterol level? _____ Don't know
24. What was your last HDL (good) cholesterol level? _____ Don't know
25. Current Height _____ Weight _____

High Blood Pressure Questionnaire

26. What type of physical activity do you currently do?

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Aerobic Workout | <input type="checkbox"/> Bicycling |
| <input type="checkbox"/> Running/Jogging | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Walking | <input type="checkbox"/> None |

27. How often do you do physical activity?

- 1-3 times a week
 3-5 times a week
 5-7 times a week
 inconsistently
 none

- | | | | |
|---|---------------------------------|--------------------------------|--|
| 28. Do you smoke cigarettes? If yes, how many cigarettes a day? _____ | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | Don't know
<input type="checkbox"/> |
| 29. How many years have you been smoking? _____ | | | Don't know
<input type="checkbox"/> |
| 30. Have you ever been enrolled in a tobacco cessation program? | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | Don't know
<input type="checkbox"/> |
| 31. Does anyone in your house smoke? | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | Don't know
<input type="checkbox"/> |
| 32. Do you drink alcohol? If yes, how much _____? | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | Don't know
<input type="checkbox"/> |

Additional Information

- | | | | |
|---|---------------------------------|--------------------------------|--|
| 33. Would you like to participate in our high blood pressure educational program? | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | Don't know
<input type="checkbox"/> |
|---|---------------------------------|--------------------------------|--|

(This a free benefit that is offered by Community Health Plan of WA.
No classes or travel are required. A nurse will call you on the telephone)

What days are best to call you?	Mon <input type="checkbox"/>	Tue <input type="checkbox"/>	Wed <input type="checkbox"/>	Thu <input type="checkbox"/>	Fri <input type="checkbox"/>	Any Day <input type="checkbox"/>
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What are the best times to call you?	<input type="checkbox"/> 7-9 am	<input type="checkbox"/> 9-11 am	<input type="checkbox"/> 11 am-1 pm
	<input type="checkbox"/> 1-3 pm	<input type="checkbox"/> 3-5 pm	<input type="checkbox"/> Anytime

- | | | | |
|---|---------------------------------|--------------------------------|--|
| 34. Is there anything else we can do to help you? | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | Don't know
<input type="checkbox"/> |
|---|---------------------------------|--------------------------------|--|

Thank you for answering these questions.
Please return this completed form in the self-addressed, stamped envelope provided and one of our Disease Management Nurses will contact you. As part of this program, we will mail educational materials to you to help you manage your high blood pressure.