

# High Blood Pressure

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

## 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?  
 What was the last reading? \_\_\_\_\_ Date : \_\_\_\_\_ Yes    No    Don't know
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?  
 If yes, have you seen a nutritionist? \_\_\_\_\_ Yes    No    Don't know
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

Community **HealthFirst**<sup>™</sup>  
Medicare Advantage Plans



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	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<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	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Does anyone in your house smoke?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Do you drink alcohol? If yes, how much \_\_\_\_\_?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Additional Information

33. Would you like to speak with one of our health educators about any questions you have about high blood pressure?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Which days are best for you?

Mon	Tue	Wed	Thu	Fri	Any Day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. What are the best times to reach 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

36. Would you like to participate in our high blood pressure educational program?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*This is a free benefit that is offered by Community Health Plan.  
No classes or travel are required.*

37. Is there anything else we can do to help you?

**Welcome to our program. Thank you for answering these questions.**

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