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| **Hypertension Clinic**Before your visit PATIENT QUESTIONNAIRE  | Image result for UNC HEALTHCARE |

Welcome to the Hypertension Clinic.

* Please answer the questions on the following pages to help us better understand your medical history.
* Bring this form when you come for your clinic appointment.

**Please print your name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What led you to schedule this appointment today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What do you consider to be your main health problems (please list 2)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did you first find out you had an issue with high blood pressure?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking any prescription medicines for your blood pressure? *Yes / No*

If yes, list the name, the dosage and how often you are taking them:

|  |  |  |
| --- | --- | --- |
| Medicine name | Dosage | How often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Do you take any over the counter medicines, vitamins or herbal remedies? *Yes / No*

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had any bad effects from a medicine or injection? *Yes / No*

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many times did you visit the emergency room for elevated BP in the past year? \_\_\_\_
2. Did you have high blood pressure or protein in your urine during your pregnancy and/or after delivery? *Yes / No / Not applicable*
3. Who manages your high BP currently? Name/Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. In the past month, how often did you forget to take one or more of your prescribed medications?

[ ] Once in the last month [ ] 2-3 times in the last month [ ] About once per week

[ ] Several times per week [ ] Nearly everyday

1. Sleep apnea screening: please check yes or no for each item:

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |
| Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? |  |  |
| Do you often feel tired, fatigued, or sleeping during daytime? |  |  |
| Has anyone seen you stop breathing during your sleep? |  |  |
| Do you have or are you being treated for high blood pressure? |  |  |

1. Do you use in any of the following? If yes, please indicate how much:

|  |  |
| --- | --- |
| Alcohol (e.g. beer, wine, liquor) | \_\_\_\_\_\_\_ drinks per day |
| Tobacco [ ] cigarettes [ ] chew/snuff [ ] cigars [ ] pipe | \_\_\_\_\_\_\_ packs per day |
| Caffeine (e.g. coffee, tea, soda, energy drinks) | \_\_\_\_\_\_\_ cups per day |
| Illicit drugs (e.g. marijuana, cocaine, heroin, other) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Exercise:

1. Do you do 30 minutes of moderate activity on most days of the week? *Yes / No*
2. Do you do “lifestyle activity” like taking the stairs instead of elevators, etc? *Yes / No*
3. Do you watch less than 2 hours or TV or videos per day? *Yes / No*
4. Please answer the following in regards to your exercise by writing the amount of time you spend for each activity in hours per day and number of days per week. If you spend no time, leave blank.

|  |  |  |
| --- | --- | --- |
|  | Hours/day | Days/week |
| How much time do you spend in moderate-intensity aerobic activity? (Activity that brings about a light sweat but you can still speak in full sentences) |  |  |
| How much time do you spend in vigorous aerobic activity? (Activity where you are not able to speak in full sentences) |   |  |
| How much time do you spend in moderate- to high-intensity muscle-strengthening activity? (e.g. weight training/ weigh bearing exercise) |   |  |

Nutrition/Diet:

1. Have you gained more than 5 pounds in the past year? *Yes / No*
2. Do you eat out at restaurants? *Yes / No* How often? \_\_\_\_\_
3. Do you consume sugar sweetened beverages (soda, tea, juice, etc)? *Yes / No* How often? \_\_\_\_\_
4. Do you add salt to food? *Yes / No*  How often? \_\_\_\_\_
5. Do you consume canned or instant foods? *Yes / No* How often? \_\_\_\_\_
6. Do you read nutrition labels on food that you buy? *Yes / No*