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HYPERTENSION QUESTIONNAIRE

(To be completed by Attending Physician)

Name of Proposer : ____________________

I.C. No. : ____________________ **Age :** _____ **Sex :** ☐ Male ☐ Female

1. Date an Elevated Blood Pressure Reading was first noticed and/or recorded

   Date : ____________________ Blood Pressure Readings : ____________________

2. What are the subsequent Blood Pressure Readings after treatment was initiated (last 3 years records only)?

Date	Blood Pressure Readings	Date	Blood Pressure Readings

3. Was any investigation carried out to ascertain the cause(s) of the Elevated Blood Pressure? E.g. Chest X-Ray, ECG, Stress SCG, Blood Tests, Scans, Microurinalysis etc.

   ☐ YES ☐ NO (If YES, please complete the details below)

Types of Investigation	Date	Results

4. Has the Proposer suffered from any End Organ Damage as a result of his/her Elevated Blood Pressure?

   (a) Heart : YES / NO (b) Brain : YES / NO

   (c) Kidney : YES / NO (d) Eyes : YES / NO

   If the answer to any of the above is YES, please indicate the extent of the Organ Damage :

   ____

   ____

   ____

5. Date and Types of Medication prescribed for the Elevated Blood Pressure over the past 3 years :

Date	Name of Medication	Dosage

6. Is the Proposer currently on Medication? ❒ YES ❒ NO

If YES, what type of medication and dosage? Medication ______________________ Dosage ______________

If NO, please provide the date and reasons the treatment was discontinued :

Date : __________________ Reasons : ____

7. Was Fundoscopy done on the Proposer? ❒ YES ❒ NO

If YES, please provide details of the Fundoscopy Results :

8. Is the Proposer regular with his/her follow-up treatment at your Clinic? ❒ YES ❒ NO

9. Does the Proposer strictly adhere to the advice and treatment prescribed by you? ❒ YES ❒ NO

10. To the best of your knowledge, is the Proposer suffering from any other illness apart from his/her Elevated Blood Pressure? ❒ YES ❒ NO

If YES, please provide details : ____

This Report has been prepared by :

Name of Doctor : ________________________________ Signature : ____________________

Clinic Rubber Stamp : ____________________________ Date : ____________________

Note: All expenses incurred in the completion of this Questionnaire have to be borne by the Proposer.