

## 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, Microurialysis 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.