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HYPERTENSION QUESTIONNAIRE

To be completed by the applicant's attending physician

ATTENDING PHYSICIAN/APPLICANT INFORMATION

NAME OF ATTENDING PHYSICIAN

NAME OF APPLICANT

DATE OF BIRTH DAY MONTH YEAR

DETAILS

1. When was elevated blood pressure first noted?

2. Please report representative readings, including the highest and lowest, with dates, before treatment was begun.

3. Were there any complications such as signs or symptoms of cardiac, renal, or retinal impairment?

☐ YES ☐ No

If "YES", please give specific data.

4. Were there any electro cardiographic or blood chemistry abnormalities?

☐ YES ☐ No

If "YES", please provide details.

5. What treatment was used?

Please give names of drugs and dosage.

6. What date was treatment started?

7. What was the response to treatment?

Please report representative post-treatment blood pressure with dates.

8. Is treatment continuing at present?

☐ YES ☐ No

If "YES", please provide names of drugs and dosage.

9. Has any consultant or other physician treated this hypertension?

☐ YES ☐ No

If "YES", please give doctors' names and addresses, with dates.

Please include copies of any relevant investigations such as ECGs, ST, ECHO and consultation reports.

SIGNATURE

A photocopy or an electronic reproduction of this document will be as valid as the original.

Attending Physician's Signature: _____ Date: _____

PLEASE RETURN FORM TO:
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