Hypertension Questionnaire

Producer Name: _____ **Contact Phone:** _____

Client Name: _____ Age: _____ DOB: _____

Sex: _____ Height: _____ Weight: _____

Client's Premium Range (what do you need in order to place the case)? [required]

_____

Any Tobacco/Nicotine Use in the Past 5yrs? ☐ Yes ☐ No If Yes, Type/Frequency/Date Last Used?

_____

Face Amount: _____ Product: _____

Any Parent or Sibling Diagnosed with Cancer, Heart Disease, Stroke, Kidney Disease or Diabetes? ☐ Yes ☐ No

If Yes, Provide Age at Diagnosis, Age at Death, or Age if Still Living:

_____

If Your Client Has a History of Hypertension, Please Answer the Following:

1. List Date of Diagnosis: _____

2. What Was the Most Recent Blood Pressure Reading? _____

3. Does Your Client Monitor at Home? ☐ Yes ☐ No How Often: _____

4. Please Check Any of the Conditions Below that the Client Has Had:

☐ Chest Pain or Coronary Artery Disease
☐ Diabetes
☐ Enlarged Heart
☐ Kidney Disease
☐ Family History of: Heart Disease, High Blood Pressure, Stroke
☐ Abnormal Lipid Levels
☐ Aneurysm
☐ Overweight
☐ TIA or Stroke
☐ Peripheral Vascular Disease

5. Has A Stress Electrocardiogram (treadmill test) Been Completed Within the Past Year?

☐ Yes; Normal Date: _____ ☐ Yes; Abnormal Date: _____ ☐ No

6. Has Client Ever Had An Echocardiogram? _____

7. Please List All Prescription and Over the Counter Medications & Dosages Currently Being Take:

Prescription, Over the Counter or Vitamins	Dosages	Reason

8. Any Additional Known Medical Conditions? _____

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