

West Allis Health Department

Employee Blood Pressure Screening Record



Employee's Name (Last, First, Middle Initial) _____

| | | | |
|--|----------------------------------|---|--|
| Telephone Number _____ | Date of Birth (mm/dd/yyyy) _____ | Age _____ | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Race (Check one) <input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other | | Ethnicity (Check one) <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Non-Latino | |

Is it okay to share blood pressure results with your healthcare provider? ☐ Yes ☐ No

If yes, Clinic Location _____ Physician _____

| | |
|--------------------------|--------------------|
| Employee Signature _____ | Date Signed: _____ |
|--------------------------|--------------------|

| B/P READINGS | | COMMENTS / NURSE SIGNATURE / INITIALS |
|--------------|------|---------------------------------------|
| B/P | DATE | |
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REFERRALS:

NURSING NOTES:

Have you ever been diagnosed with high blood pressure before? ☐ Yes ☐ No If yes, when _____

What has been / will be your plan for lowering your blood pressure?

- Lose weight _____
- Reduce sodium intake _____
- Quit smoking _____
- Increase physical activity _____
- Limit or reduce alcohol intake _____
- Take blood pressure medication? ☐ Yes When started _____ Do you take regularly? ☐ Yes ☐ No When _____
- ☐ No
- Taking a diuretic? ☐ Yes ☐ No If yes, when _____
- Taking cholesterol medication? ☐ Yes ☐ No