# Blood Pressure Screening Record

Patient's Name (Last, First, Middle Initial)

Address | PO Box | City | State | Zip

Telephone Number | Date of Birth (mm/dd/yyyy) | Age | Gender ☐ Male ☐ Female

Race (Check one)
☐ African American ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity (Check one)
☐ Hispanic / Latino
☐ Non-Hispanic/Non-Latino

Insurance Status (Check all that apply) ☐ Native American ☐ Badger Care/Medicaid ☐ Private insurance
☐ Medicaid Eligible ☐ No Health Insurance ☐ Medicare

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

If yes,
Clinic Location_____ Physician_____

Bp Results:

Social Security # if Monroe Clinic_____

SIGNATURE **X** | Date Signed

NURSE_____DATE:_____ Time: _____

NURSING NOTES:
Have you ever been diagnosed with high blood pressure before? Yes_____No_____ When_____
What has been/will be your plan for lowering your blood pressure?

a. Lose weight
b. Reduce sodium intake
c. Quit smoking
c. Increase physical activity
e. Limit or reduce alcohol intake
f. Take blood pressure medication? Yes_____When started_____Do you take regularly_____When_____
No_____
g. Taking a diuretic? Yes_____ When_____
No_____
f. Taking Cholesterol medication? Yes_____ No_____

REFERRALS:_____

COMMENTS:_____
_____
_____
_____

FOLLOW-UP B/P READINGS
B/P_____DATE_____
B/P_____DATE_____
B/P_____DATE_____