New Patient Questionnaire
Johns Hopkins Hypertension Center

Last Name:_____ **First Name:**_____
Date of Birth:_____ **Sex (circle one):** M F
Referring physician and address:_____
_____

1. When were you ***first*** told that you have, or might have, high blood pressure?
_____
_____

2. When were you ***first*** started on prescription medication for high blood pressure?
_____
_____

3. If you ever underwent any special testing to determine the cause of your high blood pressure, please describe where and when this was done, and anything you can remember about the results of the testing.
_____
_____
_____
_____

4. Please describe anything you have tried ***other than medication*** to lower your blood pressure. Include any changes in ***diet*** or ***exercise***, or any ***supplements***, ***nutrients***, or ***home remedies*** that you have tried.
_____
_____
_____
_____

5. Do you check your blood pressure outside of the doctor's office? □ yes □ no
6. If yes, where do you check it? □ at home □ at work □ in a store
7. If at home, what brand of blood pressure monitor do you use?

_____

_____

8. Please list ***all*** of the prescription medications that you have ***ever*** taken ***for high blood pressure***, and describe any side effects that you can recall from these medications:

Name of BP medication	When taken	Side effects (if any)

9. The following medications are often taken for pain or arthritis. Please circle any that you take (including over-the-counter medications).

Motrin	Advil	Aleve	ibuprofen	naproxen
Celebrex	Mobic	indomethacin	etodolac	diclofenac
sulindac	nabumetone	oxaprozin	ketorolac	

10. Do you take any over-the-counter cold medications or decongestants regularly?

_____

_____

11. Have you experienced any of the following problems or symptoms ***in the last year***?

- □ Unusual fatigue (lack of energy)
- □ Sleepiness during the day
- □ Difficulty catching your breath
- □ Swelling of your ankles or legs
- □ Constipation
- □ Skin rashes
- □ Problems with your eyesight
- □ Hay fever or allergies
- □ Numbness or tingling in your hands or feet
- □ Difficulty falling asleep
- □ Weight ***gain*** of more than 10 pounds
- □ Weight ***loss*** of more than 10 pounds
- □ Pressure or discomfort in your chest
- □ Difficulty or pain with urinating
- □ Diarrhea
- □ Bad headaches
- □ Poor hearing
- □ Pain in your joints or muscles
- □ Unusual sadness or depression
- □ Loud snoring

12. Have you ***ever*** had any of the following medical conditions?

- □ Diabetes
- □ Kidney disease
- □ Heart disease (open heart surgery, heart attack, stent placement, pacemaker, etc.)
- □ Thyroid problems
- □ Asthma
- □ Emphysema or COPD
- □ Anxiety disorder
- □ Depression
- □ Excessive alcohol use
- □ Anemia (low blood count)
- □ Arthritis

13. Have you ***ever*** been admitted overnight in a hospital (for ***any*** reason) □ yes □ no

14. Have you ***ever*** smoked cigarettes or cigars? □ yes □ no

15. Do you ***currently*** smoke cigarettes or cigars? □ yes □ no

16. How often do you drink alcohol (beer, wine, cocktails)?

□ most days □ once a week or so □ monthly or less