Hypertension Assessment

Well Aware Client's Legal Name: _____ Date:_____

Name you prefer to be called: _____

Street Address: _____ City: _____ Zip: _____

Email: _____

Best Contact Number: (____) _____ - _____ Type: Home □ Work □ Cell □

How do you prefer to be contacted to receive program information & requirements? □ Phone □ Email □ Mail

Are you an OMC employee? □ Yes □ No **If yes:** Department: _____Work hours:_____

Are you an OMC Spouse? □ Yes □ No **If yes:** Name of your spouse:_____

Demographic Info:

Date of Birth: ___/___/_____ **Gender:** □ Male □ Female

Please select the race/ethnic identity which best describes you (choose one):

- □ White
- □ Black/African American
- □ Hispanic/Latino
- □ Native American
- □ Asian (Chinese/Japanese)
- □ Pacific Islander (Vietnamese, Samoan, Filipino, etc)
- □ East Indian

What is the highest grade of school that you have completed?

- □ 8th grade or less
- □ Some high school
- □ Finished high school or have GED
- □ Some college
- □ Associate's Degree
- □ Bachelor's Degree
- □ Advanced College Degree (ex. Masters, Doctorates)

Marital Status: single □ married □ divorced □ widowed □

Health History

1. **Do you have a primary doctor?** □ Yes □ No
   a. **If "Yes", who is your doctor?** _____
   b. **If "No", do you need assistance finding a doctor?** □ Yes □ No
2. **Do you currently smoke?** □ Yes □ No
3. **Have you been hospitalized or been seen in the Emergency Department in the last year?** □ Yes □ No

Reason: _____

Medications

1. **Are you currently taking medication to treat high blood pressure?** □ Yes □ No
    a. **If "Yes", please list:**
    - Drug Name: _____ Dosage: _____
    - Drug Name: _____ Dosage: _____
    - Drug Name: _____ Dosage: _____

2. **List of other medications currently taking:**
    - Drug Name: _____ Dosage: _____
    - Drug Name: _____ Dosage: _____
    - Drug Name: _____ Dosage: _____

Meal Planning

1. **Have you ever received instructions for a specialized/restrictive meal plan?** □ Yes □ No
    a. **If "Yes", this instruction was given by:** □ Registered Dietitian
    □ Registered Nurse
    □ My physician
    □ Given only handouts to follow
    b. **If "Yes", please describe the meal plan you were given.**

_____
_____
_____

Physical Activity:

1. **What type of physical activities do you enjoy?** _____
2. **How often are you physically active?**
    □ Rarely
    □ Once a week for < 30 minutes
    □ Twice a week 30 minutes each time
    □ Every other day for 30 minutes each time
    □ Daily for at least 30 minutes each time
3. **What are reasons you are not active?**
    □ Do not know what type activities to do
    □ Not enough time
    □ Do not have a safe place to exercise
    □ Physical disability or pain
    □ Do not enjoy it
    □ Other (specify):_____

Stress:

1. **How would you rate your daily stress level?**
    □ Little stress
    □ Occasional stress
    □ Moderate stress
    □ High stress
2. **Do you believe stress causes changes in your blood pressure levels?** □ Yes □ No

3. **What is your biggest source of stress?**

□ Family
□ Work
□ Money
□ Other (specify): _____

Financial Concerns:

1. **I find it difficult to pay for my medications and often miss dosages in order to conserve money?** □ Yes □ No
2. **I find it difficult to pay for a blood pressure monitor and therefore do not test my blood pressure at home?** □ Yes □ No
3. **I do not go to my physician as often as recommended due to money concerns?** □ Yes □ No

Previous Blood Pressure Education:

1. **What are you most interested in learning about associated with high blood pressure?**

□ Causes of high blood pressure □ Medications □ Monitoring □ Complications □ Stress Management

2. **If easily accessible and free, would you be interested in attending a lunch-and-learn on high blood pressure?** □ Yes □ No

Other information I would like my Health Coach to know:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this assessment! Your responses are totally confidential, and this information will only be used by Wellness staff to better tailor the program to you and future participants.

Please return the completed form to Marlee Sheriff at the Wellness Center.

Any questions or concerns, please call 864.885.7684.

Thank you for being Well Aware of your health!