

Colonial Life Insurance Company (Trinidad) Limited
29 ST VINCENT STREET PORT OF SPAIN

HYPERTENSION QUESTIONNAIRE
(to be completed by Attending Physician)

Name: _____ Birthdate: _____

1. Date of first visit to you and reading: _____

2. Date hypertension first diagnosed prior to above: _____

3. Date of last consultation: _____

Results of: urine test _____ Blood pressure _____

EKG _____ physical check-up _____

4. Has patient, to your knowledge, ever demonstrated or are you aware of? abnormal
EKG _____ albuminuria _____

heart or vascular disorders _____ other _____

If yes, please give dates, doctors, tests, results, final diagnoses:

5. How often do you see this patient for checkups? _____

6. If any prescribed medication, please give name, quantity and frequency?

7. Has this changed since first visit? _____ If yes, how? _____

8. Compliance with treatment: good _____ fair _____ poor _____

9. Is this patient a smoker or ex-smoker? _____

If Yes, date last smoked: _____ quantity: _____

how many years: _____ type of tobacco: _____

10. Additional comments you might wish to make: _____

Date

(Attending Physician's Signature)