HIGH BLOOD PRESSURE CARE PLAN

Name: ______________________________

Date: _______________ **D.O.B.** __________

Provider's name: _______________________

What I will take care of:

☐ Check my blood pressure (fill in the box below with your doctor)

☐ Keep a blood pressure log and bring it to my appointments

☐ Take medicine as prescribed, even when I feel well

☐ Eat better, including eat 5 fruits and vegetables daily

☐ Reduce salt in my diet

☐ Be active, exercise _____ minutes _____ days per week

☐ Try to lose some weight: _____ pounds

☐ Talk to my medical provider if I am having problems or have questions about my high blood pressure

☐ Stop smoking or chewing

How confident I feel that I can achieve these goals:

☐ Confident

☐ Neutral

☐ Not confident

☐ Unsure

Goals for testing blood pressure:

I plan to test my blood pressure _____ time(s) per week.

My target blood pressure is:

☐ Less than 140/90 ☐ Less than 130/80

My numbers:

Blood Pressure __________

(Ideal: 140/90 or less; If you have diabetes or kidney disease, 130/80 or less)

LDL ("bad" cholesterol) __________

(Ideal: 100 or less)

Please see your visit summary for any changes that were made to your medications at this visit.

Patient Signature ___________________

Here are some resources to help you learn more about high blood pressure and ways to be healthier:

- Call our clinic to sign up for our weight loss program or to meet with a dietician
- Visit www.nhlbi.nih.gov/hbp for more information about your condition
- Visit www.kanquit.org or call 1-800-QUIT-NOW for help with quitting smoking
- For a free self-management tool visit www.MerckEngage.com
- Enroll in the "Healthy Options" program if your primary insurance is Blue Cross/Blue Shield of KS

Tips for living a healthier and longer life:

- *Avoid excessive alcohol use and tobacco*
- *Improve nutrition*
- *Engage in physical activity*