High Blood Pressure

Community HealthFirst™ Medicare Advantage Plans

COMMUNITY HEALTH PLAN of Washington
Committed to your health.

Name: _____ **Date Completed:** _____
Member #: _____ **Date of Birth:** _____

Thank you for taking the time to complete this questionnaire. Your answers are important and will help us to meet your health care needs. This questionnaire will take about 10 minutes to finish

General Information

1. What is your address and best contact telephone number?

_____ ( ) _____
(Address) (City, State, Zip code) (Phone number)

2. What is your primary language? Do you need an interpreter? Yes ☐ No ☐ Don't know ☐

3. What is the name of the doctor or care provider you see most? _____

Clinic Name/Address: _____ Phone: ( ) _____

General Health Information

4. Have you had a flu shot? Yes ☐ No ☐ Don't know ☐
If yes, what was the date of your last flu shot? _____

5. Have you had a pneumonia shot? Yes ☐ No ☐ Don't know ☐
If yes, what was the date of your last pneumonia shot? _____

6. Are there any other medical problems you are being treated for? Yes ☐ No ☐ Don't know ☐
If yes, please explain: _____
_____
_____

7. In the last 6 months, have you been to the emergency room (ER) for high blood pressure? If yes, how many times? _____ Yes ☐ No ☐ Don't know ☐

8. What are your health goals and interests?
☐ Eating better ☐ Reducing stress ☐ Losing weight
☐ Exercising ☐ Aging well ☐ Other

Medication Information

9. What prescription medications do you take?
Please list: _____
_____
_____

10. Do you take non-prescription medications or supplements (for example, aspirin, vitamins, etc.)? If yes, please list: _____ Yes ☐ No ☐ Don't know ☐
_____
_____
_____

11. Have you been taking your medications as prescribed by your doctor? Yes ☐ No ☐ Don't know ☐
If no, why not? _____

12. Are you having any problems taking your medications? Yes ☐ No ☐ Don't know ☐
If yes, please explain: _____

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High Blood Pressure Information

13. Has your doctor told you that you have High Blood Pressure? Yes ☐ No ☐ Don't know ☐

14. How often do you see your doctor for blood pressure checkups?
- ☐ *monthly*
- ☐ *every 3-4 Months*
- ☐ *every 6 months*
- ☐ *once a year*

15. What was your last systolic blood pressure reading? (top number) _____ Don't know ☐

16. Your last diastolic blood pressure reading? (bottom number) _____ Don't know ☐

17. Have you had a blood pressure reading of 140/90 or less in the last year? Yes ☐ No ☐ Don't know ☐

18. Do you take your blood pressure at home? Yes ☐ No ☐ Don't know ☐
What was the last reading? _____ Date : _____

19. Which of the following symptoms have you had?
- ☐ *Blurry Vision*
- ☐ *Chest Pain*
- ☐ *Dizziness*
- ☐ *Headaches*
- ☐ *None*
- ☐ *Other*_____

20. Does high blood pressure affect the ability to perform your usual daily activities? If yes, how? _____ Yes ☐ No ☐ Don't know ☐

21. Select the type of diet you are following. Yes ☐ No ☐ Don't know ☐
- ☐ Diabetic
- ☐ Low Carbohydrate / Sugar
- ☐ Low Cholesterol
- ☐ Low Salt
- ☐ Renal (Low Protein/Low Salt)
- ☐ Weight Reduction
- ☐ Vegetarian
- ☐ No Special Diet

22. Have you been told you have high cholesterol? Yes ☐ No ☐ Don't know ☐
If yes, have you seen a nutritionist? _____

23. What was your last LDL (bad) cholesterol level? _____ Don't know ☐

24. What was your last HDL (good) cholesterol level? _____ Don't know ☐

25. Current Height _____ Weight _____

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26. What type of physical activity do you currently do?

- ☐ Aerobic Workout
- ☐ Bicycling
- ☐ Running/Jogging
- ☐ Swimming
- ☐ Walking
- ☐ None

27. How often do you do physical activity?

- ☐ 1-3 times a week
- ☐ 3-5 times a week
- ☐ 5-7 times a week
- ☐ inconsistently
- ☐ none

	Yes	No	Don't know
28. Do you smoke cigarettes? If yes, how many cigarettes a day? _____	☐	☐	☐
29. How many years have you been smoking? _____			☐
30. Have you ever been enrolled in a tobacco cessation program?	☐	☐	☐
31. Does anyone in your house smoke?	☐	☐	☐
32. Do you drink alcohol? If yes, how much _____?	☐	☐	☐

Additional Information

	Yes	No	Don't know
33. Would you like to speak with one of our health educators about any questions you have about high blood pressure?	☐	☐	☐

34. Which days are best for you?

Mon	Tue	Wed	Thu	Fri	Any Day
☐	☐	☐	☐	☐	☐

35. What are the best times to reach you?

- ☐ 7-9 am
- ☐ 9-11 am
- ☐ 11 am-1 pm
- ☐ 1-3 pm
- ☐ 3-5 pm
- ☐ Anytime

	Yes	No	Don't know
36. Would you like to participate in our high blood pressure educational program?	☐	☐	☐

This is a free benefit that is offered by Community Health Plan.
No classes or travel are required.

37. Is there anything else we can do to help you?

Welcome to our program. Thank you for answering these questions.
Please return this completed form in the self-addressed, stamped envelope provided and one of our Disease Management Representatives will contact you. As part of this program, we will mail educational materials to you to help you manage your high blood pressure.