Walgreens

007_Forms

The PharmD Hypertension Project
History and Physical

I.D. NUMBER_____   DATE_____

NAME_____

ADDRESS_____

PHONE_____

DATE OF BIRTH_____MALE_____FEMALE_____

Primary care physician: Name_____Phone_____

Ethnic origin: <u>Circle one</u>   Caucasian   Hispanic   African-American   Asian

Presence of cardiovascular disease: Yes_____No_____

❖ <u>**Major risk factors for cardiovascular heart disease**</u>

- <u>**Elevated blood pressure:**</u>   Yes_____No_____Treated_____Untreated_____

- <u>**Smoker:**</u>   Current_____Past_____Never_____

- <u>**Diabetes Mellitus:**</u>   Yes_____No_____

- <u>**Age:**</u> _____

- <u>**Physical Activity:**</u>   Exercise - Hours per week_____

❖ **Measurements**

Date	Time	Blood Pressure	Pulse	Recommendations

❖ **Obesity**

Date	Weight	Height	BMI

❖ **Cholesterol levels**

Date	HDL	LDL	Total Cholesterol	TriG

Created by: L.A.K.

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NSU NOVA
SOUTHEASTERN
UNIVERSITY
College of Pharmacy

I.D. NUMBER_____   DATE_____

NAME_____

RECOMMENDATIONS

☐ 1. Return in one week to pharmacy for repeat blood pressure reading.

☐ 2. Return in one month to pharmacy for repeat blood pressure reading.

☐ 3. Return in two months to pharmacy for repeat blood pressure reading.

☐ 4. Schedule visit with your physician Dr. _____

for follow-up of high blood pressure within the next week.

☐ 5. Schedule visit with the pharmacist for cholesterol screening and/or

counseling.

☐ 6. Blood pressure within normal limits, patient to follow up with

physician on a regular basis.

Date	Blood Pressure	Pulse

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Pharmacist Counseling Appointment Form

I.D. NUMBER_____   DATE_____

NAME_____

ADDRESS_____

PHONE_____

Pharmacist Appointment Date_____

Appointment Time_____a.m._____p.m.

➢ **Please bring a list of all the medicines you take regularly, including vitamins or over-the-counter products.**

➢ **Please call us at _____ to reschedule your appointment, if you will be unable to meet with the pharmacist at this time.**

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Physician Referral Form

I.D. NUMBER_____   **DATE**_____

NAME_____

ADDRESS_____

PHONE_____

DATE OF BIRTH_____**AGE**_____**Male**_____**Female**_____

Patient's Needs:_____

_____

_____

_____

Referred to:_____

Appointment Date_____**Time**_____a.m_____p.m.

Referred by:_____

Pharmacist Phone Number_____

Created by: L.A.K. 4/03