

# HYPERTENSION

AGENT NAME: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_

Date: \_\_\_\_\_

1. Date of diagnosis: \_\_\_\_\_

2. What was the most recent blood pressure reading? \_\_\_\_\_

3. Please check any of the below that client has had:

- Chest pain or coronary artery disease
- Diabetes
- Family history of: heart disease, high blood pressure, stroke
- Abnormal lipid levels
- TIA or stroke
- Enlarged heart
- Aneurysm
- Peripheral vascular disease
- Kidney disease
- Overweight

4. Has a stress electrocardiogram (treadmill test) been completed within the past year?

- Yes; normal    Date: \_\_\_\_\_     Yes; abnormal    Date: \_\_\_\_\_
- No

5. Has client ever had an echocardiogram?     No     Yes

6. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Does client have any other major health issues? (additional questionnaires may be required)     No     Yes; please give details

\_\_\_\_\_  
\_\_\_\_\_

**Save and Email Completed Form to: [quotes@levelfourinsurance.com](mailto:quotes@levelfourinsurance.com)**

© Level Four Insurance Agency | Toll Free: 800.460.5567 | Fax: 214.556.2708 | [www.levelfourinsurance.com](http://www.levelfourinsurance.com)