

# HYPERTENSION

**Client's Name** \_\_\_\_\_

If you client has a history of high blood pressure, please answer the following:

1. Please list date when first diagnosed: \_\_\_\_\_
2. What was the most recent blood pressure reading? \_\_\_\_\_  
**(Client may need to contact their physician's office for this information).**
3. Is your client on any medications?  
 yes, please give details \_\_\_\_\_  
 no
4. Please check if you client has had any of the following:  
 chest pain or coronary artery disease  
 diabetes  
 family history of heart disease, high blood pressure, stroke  
 elevated cholesterol  
 TIA or stroke  
 enlarged heart  
 aneurysm  
 peripheral vascular disease  
 kidney disease  
 overweight
5. Has your client smoked cigarettes in the last 12 months?  
 yes  
 no
6. Does your client have any other major health problems (example: cancer, etc.)?  
 yes, please give details \_\_\_\_\_  
 no

Agents name:

Agents Tell #

Agent Fax #

Date Submitted:

Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775