Blood Pressure Questionnaire

Title ☐ Surname ☐

Given name(s) ☐

Date of birth ☐ / /

1 (a) What was your last blood pressure / cholesterol reading and when was this taken? (Please indicate which condition you have)

Blood Pressure ☐ Systolic ☐ Diastolic ☐ Date / /

Cholesterol ☐ Reading ☐ Date / /

(b) Is this reading consistent wth others when checked?

No ☐ What is your typical reading? ☐

Yes ☐

2 When are you due for your next check up?

☐

3 How often are you required to attend your doctor for review/ check ups?

Monthly ☐ Twice yearly ☐

Quarterly ☐ Annually ☐

4 When were you first told you had raised blood pressure / raised cholesterol?

☐

5 Are you currently taking medication for your blood pressure / cholesterol levels?

No ☐ ***Go to Question 7***

Yes ☐ Please provide names and medication and daily dosage

☐

6 Has your treatment (type or dosage) been changed within the last 12 months?

No ☐ ***Go to Question 8***

Yes ☐

When was it changed? ☐

What was changed? ☐

Why was it changed? ☐

Go to Question 8

7 Have you ever been prescribed medication for blood pressure / cholesterol?

No ☐ How has the condition been managed? (eg: Diet, exercise)

☐

Yes ☐ When and why did you cease taking this?

☐

8 What was your blood pressure / cholesterol reading at the time of diagnosis?

Blood pressure (eg 120/80) ☐ Systolic ☐ Diastolic

Cholesterol ☐ Reading

9 Have you undergone or been referred for any other investigations: eg ECG (resting or exercise stress), Echocardiogram, 24 hr Holter monitoring, urinalysis?

No ☐
Yes ☐

What were the results?

Who holds the results of any investigations (eg GP)?

10 Has any underlying cause been found for your raised blood pressure / cholesterol?

No ☐
Yes ☐

Please provide full details

DECLARATION

The answers to the questions above are true and complete and this supplementary questionnaire forms part of my application for insurance.

Signature

X Date / /

Please return this completed form to:

Smartsave
PO Box 1282
Albury
NSW 2640