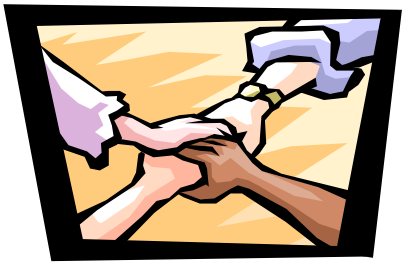
Your Name: _____ ID:_____ Date: _____



TEAM PROGRAM: Working Together for Healthy Blood Pressure (BP)

Health Checklist

Dear Patient:

Welcome to the TEAM Program! Our goal is to work together as a team with you and your doctor to keep your blood pressure (BP) in the healthy range.

This Health Checklist will help us assess your health history and risk for heart disease, the steps you already have taken to lower your blood pressure, and your goals for the next six months.

If you are not sure how to answer a question, just let us know so we can assist you.

SCHOOL OF PHARMACY
University of Wisconsin-Madison

A. YOUR HEALTH HISTORY

1. Have you **ever** had the following conditions? Check ☑ all the boxes that apply.

☐ Diabetes	☐ Weak or failing kidneys
☐ A heart attack	☐ Kidney dialysis
☐ Congestive heart failure	☐ Narrowing of the arteries
☐ Enlarged heart	☐ Speech difficulty
☐ Angina (chest pain)	☐ Weakness on one side
☐ A coronary bypass	☐ Slurred speech
☐ A stroke	☐ Loss of balance
☐ High cholesterol	☐ Faint or lose consciousness

2. Has your doctor ever told you to avoid brisk walking or exercise? ☐Yes ☐ No

3. What is your height? ___feet ___ inches. What is your weight? ____pounds

4. Would you like to: ☐ lose weight ☐ gain weight ☐ stay the same

5. Do you smoke? ☐Yes ☐ No

B. YOUR BLOOD PRESSURE GOAL

1. Did your doctor ever tell you what your blood pressure numbers should be? ☐ Yes ☐ No

2. What do you think your blood pressure numbers should be?

☐ My blood pressure numbers should be ____/____ or lower
☐ I don't know

3. How concerned are you about your blood pressure level at this time?

☐ Very concerned ☐ Somewhat concerned ☐ Not at all concerned

C. YOUR LIFESTYLE AND SELF-CARE

	How often do you…	A. Usually/ often	B. Sometimes	C. Rarely/ never
	1.Take your medication at the same time(s) every day?	☐	☐	☐
	2. Use a pill box to help remember your medication?	☐	☐	☐
	3. Keep your medication where you will be reminded to take it ?	☐	☐	☐
	4. Do brisk walking or exercise at least 30 minutes a day, most days of the week?	☐	☐	☐
	5. Use food labels to help you choose products that are low in salt?	☐	☐	☐
	6. Taste before adding salt to food at the table?	☐	☐	☐
	7. Choose low-salt snacks instead of salty chips or nuts?	☐	☐	☐
	8. Avoid high-salt frozen or packaged dinners, soups, and pizza?	☐	☐	☐
	9. Avoid ham, bacon, hot dogs, and lunch meat with a lot of sodium?	☐	☐	☐
	10. Eat <u>less than</u> three meals a week from a fast food or sit-down restaurant?	☐	☐	☐
	11. Eat at least 4 servings of fruit a day? Serving= ½ cup fruit, 1 medium fruit, ¼ cup dried fruit, 6 oz juice	☐	☐	☐
	12. Eat at least 4 servings of vegetables a day? Serving= 1 cup leafy raw vegetables, ½ cup vegetables, 6 oz juice.	☐	☐	☐
	13. Use low-fat dairy food like 1% or skim milk or fat-free yogurt?	☐	☐	☐
	14. Eat lean meat, poultry, and fish instead of higher fat red meat	☐	☐	☐
	15. Limit foods with lots of sugar like pie, candy, ice cream, soda	☐	☐	☐
	16. Eat smaller portions to lose or keep normal weight?	☐	☐	☐
	17. Limit your use of alcohol Men: no more than 2 drinks per day Women: no more than 1 drink/day One drink= 12 oz. beer, 5 oz. wine, or 1 shot of hard liquor	☐	☐	☐
	18. Check your blood pressure at least once a month?	☐	☐	☐
	19. Write down your blood pressure numbers?	☐	☐	☐

D. YOUR GOALS FOR THE NEXT 6 MONTHS

1. Look back at **YOUR LIFESTYLE AND SELF-CARE** (page 3). Do you have any answers in Column A? If so, good for you!! You already are taking steps to help lower your blood pressure and protect your heart.

2. Now, think about your goals for the next six months. Are you willing to get your blood pressure checked and meet with your pharmacist once a month?

☐ Yes ☐ No

3. What changes would you like to make in your use of medication, physical activity, use of salt, eating habits, or other things to lower your blood pressure in the next 6 months? Please list these changes in order of importance to you.

Changes I would like to make in the next 6 months	
1	
2	
3	

4. Select one of the changes you listed above. Please write down one small, achievable goal that you would like to reach in this area during the next month. (Example: I would like to walk 10 minutes a day four days a week)

During the next month, I would like to: _____

_____.