

Mr/Mrs: \_\_\_\_\_; Age: \_\_\_\_\_

## GUIDELINE WORKSHEET "Subjects Without Known Hypertension"

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

Please, answer the following questions (tick or cross):

**Do you suffer from one of the following diseases?** (multiple choices possible)

- Diabetes  Heart failure  
 Coronary heart disease  Stroke  
 Chronic kidney disease  Myocardial infarction ("Heart attack")

**Do you currently smoke?**

- No  Yes

**Does one of these diseases exist in your family (1<sup>st</sup> degree relative)?**

- No  Yes

### FILLED-IN BY THE PHARMACY:

After 5 min rest, we measured the following blood pressure and pulse rates

right /  left  upper arm /  wrist while seated:

**1<sup>st</sup> Measurement:** \_\_\_\_\_ / \_\_\_\_\_ mmHg Pulse: \_\_\_\_\_ min<sup>-1</sup>

**2<sup>nd</sup> Measurement:** \_\_\_\_\_ / \_\_\_\_\_ mmHg Pulse: \_\_\_\_\_ min<sup>-1</sup>  
(1–2 min after the 1<sup>st</sup> measurement)

**3<sup>rd</sup> Measurement:** \_\_\_\_\_ / \_\_\_\_\_ mmHg Pulse: \_\_\_\_\_ min<sup>-1</sup>  
(1–2 min after the 2<sup>nd</sup> measurement)

**Mean:** \_\_\_\_\_ / \_\_\_\_\_ mmHg Pulse: \_\_\_\_\_ min<sup>-1</sup>  
(of 2<sup>nd</sup> and 3<sup>rd</sup> measurements)

The **mean** of the 2<sup>nd</sup> and 3<sup>rd</sup> measurements and the age are resulting in the following recommendation:

<80 years	80 years and older	Recommendation (tick or cross)
>140 mmHg systolic <i>or</i> >90 mmHg diastolic	>160 mmHg systolic <i>or</i> >90 mmHg diastolic	<input type="checkbox"/> Please, make an appointment with your physician within 4 weeks
130–140 mmHg systolic <i>or</i> 85–90 mmHg diastolic	130–160 mmHg systolic <i>or</i> 85–90 mmHg diastolic	<input type="checkbox"/> Please, repeat blood pressure measurements at least annually
<130 mmHg systolic <i>and</i> <85 mmHg diastolic	<130 mmHg systolic <i>and</i> <85 mmHg diastolic	<input type="checkbox"/> Please, repeat blood pressure measurements at least every 3 years

**Indication of arrhythmias:**  No  Yes (if not already known, please make an appointment with your physician as soon as possible)

\_\_\_\_\_  
Your contact person in the pharmacy

\_\_\_\_\_  
Pharmacy Stamp / Signature

**Please, share this worksheet with your physician. If necessary, he/she will discuss diagnostic and therapeutic options with you.**

