



# CARDIAC/HYPERTENSION QUESTIONNAIRE

**(Please complete this form for each person listed on the application who has hypertension and/or cardiac conditions.)**

Patient's Name	Applicant's Name (if different from patient)
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Please answer the following questions about you or your dependent's high blood pressure. If you are not sure about an answer, your physician will be able to provide you with the necessary information, or may complete this questionnaire on your behalf. Your complete and honest answers will help to determine eligibility for coverage. Incomplete or inaccurate information on this form may lead to denial of claims and/or cancellation of coverage, as explained on your application and health statement.

1. How long has patient had high blood pressure? \_\_\_\_\_
2. Please give the most recent blood pressure readings and date, as listed below:
 

(a) Prior to Treatment, if information is available	(b) During Treatment, within the last year
Mo. _____ Yr. _____ Reading _____	Mo. _____ Yr. _____ Reading _____
Mo. _____ Yr. _____ Reading _____	Mo. _____ Yr. _____ Reading _____
Mo. _____ Yr. _____ Reading _____	Mo. _____ Yr. _____ Reading _____
3. Please give the name, strength, and dosage of each prescription drug taken for high blood pressure during the past three years: \_\_\_\_\_  
 Give name, strength, dosage, and length of time on current medication: \_\_\_\_\_
4. Does the patient take any other prescription drug(s) for treatment of other medical conditions?  Yes  No  
 If Yes, please give the name of the drug, the dosage, and the condition for which it is being taken: \_\_\_\_\_
5. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Has there been any marked change in patient's weight during the past two years?  Yes  No  
 Amount gained \_\_\_\_\_ lbs. Amount lost \_\_\_\_\_ lbs.
6. Does the patient have any other circulatory, kidney, or heart conditions?  Yes  No  
 If Yes, list condition, date diagnosed, and treatment, including dates: \_\_\_\_\_
7. Has the patient ever had heart surgery, any other heart or circulatory condition, or any of the following: stress test, treadmill, echocardiogram, holter monitor or cardiac catheterization?  Yes  No  
 If Yes, list condition, date diagnosed, and treatment, including dates: \_\_\_\_\_  
 Physician's name and address: \_\_\_\_\_

### — Agreement —

I understand this questionnaire is attached to and becomes part of my application and health statement. I understand conditions of my application for health coverage previously agreed to by me on my application and health statement are applicable to my answers to this questionnaire.

BLUE CROSS AND BLUE SHIELD OF GEORGIA is authorized to present a copy of this signed Agreement to any hospital, physician, other provider of care in order to obtain any medical information regarding myself or any listed family member.

\_\_\_\_\_  
 Patient's Signature Date  
*(if different from applicant)*

\_\_\_\_\_  
 Physician's Signature Date  
*(needed only if the physician has filled out this form on behalf of the patient)*

\_\_\_\_\_  
 Applicant's Signature Date