



Name: \_\_\_\_\_

Questions for your doctor:

1)

2)

3)

Current blood pressure medications:

Please log the following:

Date	Time (AM/PM)	Blood Pressure	Symptoms (if any)	Activity (i.e. working, cleaning, etc.)
8/24/15	10:12 AM	148/89	headache	at work

Please fill out this form and bring to every clinic visit. Thank you!

