My Hypertension Care Plan

Name: «PatientFullName»
DOB: «PatientDateOfBirth»

Provider: «EncounterProviderName»

Clinic Name: «OfficeLocationName»
Clinic Phone # : «OfficeLocationPhone»
Date: «CurrentDate»

Use the results: Write them down on a log sheet or record book. Bring them to your next appointment. The results help you and your provider make decision about your treatment plan.

Add flavor not sodium. Flavor foods with…lemon juice, citrus zest, herb spice blends, low-sodium broth, black pepper and fresh garlic. Choose foods rich in potassium and calcium like broccoli, oranges, apples, pears and peaches. Drink non-fat or 1% milk, yogurt and reduced fat cheeses.

Labs and Exam	Goal	My Results
Blood Pressure	Less than 140/90 Twice a year	- «VitalsBloodPressure»
Fasting Blood Sugar	1 time per year	
Lipid Panel	LDL less than 100 or ___ Once a year	
Urinalysis		
Smoking Status	Stop Smoking	
Sodium Intake	DASH diet	
CMP	1-2 times a year	
Weight	Short-term goal ________	«VitalsWeight»
Flu Shot	Once a year	
EKG	Baseline	

My Self-Management Plan

1. I will reduce stress by doing something I enjoy, a hobby, exercising/walking or meditating. When I feel stressed out, I will find someone to talk to or seek help.
2. I will walk 30 minutes ____ day(s) a week. If I notice chest pain, shortness of breath, or chest tightness, I will seek medical attention.
3. I will decrease the amount of salt I use every day. No added salt in cooking or at the table. (Review food sources)
4. I will follow a low fat and low cholesterol diet to reduce my cholesterol and reach or maintain a lower weight. DASH diet.
5. I will achieve a lower body weight aided by exercise and dietary management. I will lose ______ pounds by ________________.
6. I will take all medications as prescribed every day. To reduce risk of blood clots, stroke or heart attack, I will take an aspirin a day. Aspirin: either 81 mg or 325 mg daily

7. I will stop smoking. I will discuss smoking cessation measures, support groups and possible prescription medications with my clinician.
8. I will visit the eye specialist every year or as indicated or recommended. Next appointment due __________________
9. I will limit alcohol to 1 glass per day. Should not exceed 1 ounce or 1/8 cup liquor, **<u>or</u>** 24 ounces of beer, **<u>or</u>** 10 ounces of wine, **<u>or</u>** 3 ounces of 80 proof whiskey.
10. I will achieve a lower blood pressure of ___/___ or less by ____________________. Follow up blood pressure readings and medication adjustments/additions as indicated.

I choose goal: ________________________

How likely are you to follow through with these activities prior to your next visit?
Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

When to call the healthcare provider:

- Your blood pressure is 140/90 or higher on two or more occasions
- You think you may be having side effects from your blood pressure medicine
- Your blood pressure is usually normal and well controlled, but it goes above the normal range on more than one occasion.
- Severe headaches, blurry vision, nausea, vomiting, dizziness, fatigue and weakness.
- Chest pain and/or shortness of breath.

<u>My Medications</u>
«MedsCurrentWithSig»

The following medications were **ordered**: «MedsNewWithSig»

«ReferringProviderFullName»
<u>Future Appointments</u>: ____