



Trials of Hypertension Prevention
(TOHP), supported by the National
Heart, Lung, and Blood Institute,
National Institutes of Health

Visit _____
ID number _____
Initials _____
Visit date ____/____/____

TRIALS OF HYPERTENSION PREVENTION
Follow-Up Visit
Health Experience Form

Please complete all questions to the best of your ability. If you have trouble answering any questions, a staff member will assist you.

The date when you last provided health history information was _____
(date of last visit)

1. Since your last visit, has a doctor told you that you had any of the following?
(Please check Yes, No or Not Sure for each item)
- | | Yes | No | Not Sure |
|---|---------|---------|----------|
| a) High blood pressure (hypertension) | ___ (1) | ___ (2) | ___ (3) |
| b) Serious heart condition, such as a heart attack, angina,
intermittent claudication or congestive heart failure? | ___ (1) | ___ (2) | ___ (3) |

2. Have you seen a physician since your last visit? Yes ___ (1) No ___ (2)
If yes, reason _____
Date ____/____/____

2a. Have you been hospitalized or had surgery since your last visit? Yes ___ (1) No ___ (2)
If yes, reason _____

3. Are you scheduled to see a physician? Yes ___ (1) No ___ (2)
If yes, when? ____/____/____
What for? _____

4. Are you currently pregnant? Male ___ (3) Female Yes ___ (1) No ___ (2)

5. Has anything changed regarding your health status? Yes ___ (1) No ___ (2)
If yes, describe _____

Clinical
Reviewer ID _____

6. On average, how many 12-oz. cans or bottles of beer do you usually drink per week?
___ none
___ less than 1/week
___ ___ beers per week

On average, how many 4-oz. glasses of wine do you usually drink per week?
___ none
___ less than 1/week
___ ___ glasses per week

On average, how many drinks (cocktails, hard liquor, liqueurs equal to 1½ oz. liquor) do you usually drink per week?
___ none
___ less than 1/week
___ ___ drinks per week

7. Have you ever smoked cigarettes (more than 1 per day)? Yes ___ (1) No ___ (2)
If no, stop.
If yes, at what age did you start? ___ years
Do you currently smoke cigarettes? Yes ___ (1) No ___ (2)
If no, at what age did you stop? ___ years
When you smoke or smoked, on average how many cigarettes per day do/did you smoke? ___ cigarettes/day

Staff ID _____

Editor ID _____