



Veteran

UIN

Please assess the following conditions:

1. Is the veteran on **medication for hypertension**? ☐ Yes ☐ No

2. Please select the most accurate description of any **side effects** of any medication.

Description	Select One
No medication or no side effects.	<input type="checkbox"/>
Frequent minor side effects which cause no loss of function.	<input type="checkbox"/>
Side effects causing a significant and persistent loss of function .	<input type="checkbox"/>

3. Please select the most accurate description of the **control of hypertension**. (For the purposes of this assessment only diastolic pressure is relevant).

Description	Select One
Controlled hypertension (diastolic pressure less than 90 mm Hg).	<input type="checkbox"/>
Diastolic pressure consistently between 90 mm Hg and 100 mm Hg .	<input type="checkbox"/>
Diastolic pressure consistently greater than 100 mm Hg .	<input type="checkbox"/>

4. Please select **all** that apply in relation to any **target organ damage**. Other conditions with hypertension as a risk factor (e.g. IHD / atherosclerotic disease) should not be included.

Description	Select
Hypertensive retinopathy (grade III or IV).	<input type="checkbox"/>
Hypertensive cardiac disease.	<input type="checkbox"/>
Hypertensive nephropathy.	<input type="checkbox"/>
Hypertensive cerebral haemorrhage.	<input type="checkbox"/>

Doctor's signature	Doctor's name	Date	Time to complete form
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>