Kepple Lane PHARMACY

Blood Pressure Record Form

Title	Mr	Mrs	Miss	Ms	Other
Name					
Address					
Telephone					
Post Code					
Email					

I agree that the information obtained during the service can be shared with:

- my doctor (GP) to help them provide care to me

Signature/ Date	

Do you suffer any medical conditions?

Diabetes	Yes/No
Epilepsy	Yes/No
Migraines	Yes/No
Heart Conditions	Yes/No
Lung Conditions	Yes/No
Pregnant	Yes/No
Dizziness / Vertigo	Yes/No

Please list current medication from doctor below

Please list any alternative medication / Over the counter medication / Any vitamin supplements you may be taking

Blood Pressure Record

Date	Reading	Pulse	Comment	Pharmacist Check