HIGH BLOOD PRESSURE ACTION PLAN

Name: _____

Medical Provider's	Clinical Case Manager's
Name: _____	Name: _____
Phone: _____	Phone: _____

THINGS TO DO EVERYDAY:

- ☐ Take my medicines as directed
- ☐ Keep a healthy weight
- ☐ Eat a healthy diet which includes lots of fruits and vegetables
- ☐ Eat a diet high in fiber, low in fat and cholesterol
- ☐ Choose low-fat dairy foods
- ☐ Read labels for hidden salt
- ☐ Bake, broil, grill, roast, steam, and poach foods
- ☐ Exercise regularly, such as walking for 30 minutes a day
- ☐ Limit alcohol

THINGS TO AVOID:

- ☐ Adding salt to my diet
- ☐ Eating food high in salt
- ☐ Prepared or canned food high in calories or salt
- ☐ Smoking or using tobacco products
- ☐ Naproxen/ibuprofen unless prescribed
- ☐ Stress

I WILL CALL MY MEDICAL PROVIDER TODAY IF:

- ☐ I am having problems with my medicines
- ☐ My blood pressure is:
  greater than _____or lower than_____
- ☐ I am having headaches with dizziness that do not stop when I take my medicine

MY PLAN:

I will discuss with my medical provider:

- ☐ Changes in diet
- ☐ Activity/Exercise
- ☐ Yearly Flu vaccine

I WILL CALL 911 IF:

- ☐ I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea
- ☐ I have a sudden, severe headache with no known cause
- ☐ I have sudden weakness or numbness of my face, arm or leg
- ☐ I have sudden confusion, trouble speaking or understanding others
- ☐ I have sudden loss of balance, dizziness or difficulty seeing

GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:
Date:	My LDL Cholesterol:	My Goal:
Date:	My Total Cholesterol:	My Goal:

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MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)	Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important 1 2 3 4 5 6 7 8 9 10 Totally important

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):