

# Blood Pressure Record

The following information is required:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Phone number where you can be reached: \_\_\_\_\_

Best time of day to be called: \_\_\_\_\_

Email address: \_\_\_\_\_

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## Health Care Provider Use only

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Date of blood pressure reading: \_\_\_\_\_

Blood pressure: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_

Contact phone # \_\_\_\_\_

Health Care Provider Name (printed): \_\_\_\_\_ Title: \_\_\_\_\_

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**Information for the patient: please mail or fax this form to:**

**Online Health Center  
3231 SE 50th Avenue  
Portland, Oregon 97206  
Fax Number: 503-788-7278**

**If you have any questions regarding this form, your blood pressure, or refills of your birth control method, please call Monday – Friday, 9:00 a.m. to 5:00 p.m.:  
503-788-7273 or toll free 1-888-875-7820**