JMR MEDICAL SERVICES

CHRONIC CONDITION CHECKLIST

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A comprehensive guide for managing hypertension, diabetes, and heart disease with our care team.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Date: _____

Care Team / Provider: _____

1. KNOW YOUR NUMBERS

Blood Pressure: _____ Date: _____

Blood Sugar / Glucose: _____ Date: _____

A1C: _____ Date: _____

Cholesterol: _____ Date: _____

Weight: _____ Date: _____

2. HYPERTENSION / HIGH BLOOD PRESSURE

■ Blood pressure readings ■ Medication schedule ■ Low-sodium eating

■ Physical activity ■ Weight goals ■ Home monitoring

Questions or concerns: _____

_____

3. DIABETES / BLOOD SUGAR MANAGEMENT

■ Glucose monitoring ■ A1C ■ Medication plan ■ Nutrition

■ Physical activity ■ Foot care

Questions or concerns: _____

_____

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4. HEART HEALTH

■ Blood pressure ■ Cholesterol ■ Medications

■ Physical activity ■ Heart-healthy eating ■ Smoking/nicotine

New or worsening symptoms to discuss:

_____

_____

5. MEDICATION MANAGEMENT

I reviewed my current medication list: ■ Yes ■ No ■ Needs updating

Medication questions, side effects, or refill needs:

_____

_____

6. HEALTH HABITS & GOALS

■ Take medications as directed ■ Monitor health numbers

■ Increase activity ■ Improve nutrition

■ Improve sleep ■ Keep appointments

My personal goal: _____

How my care team can support me:

_____

7. FOLLOW-UP

■ I understand my current care plan.

■ I know how and when to take my medications.

■ I know which health measurements to monitor at home.

■ I know when to contact my care team with concerns.

Next appointment: _____ Provider: _____

NOTES FOR MY CARE TEAM

This checklist supports conversations with your healthcare team and does not replace individualized medical advice.

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