



BAYLOR HEART CLINIC
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BAYLORHEART
CLINIC

CARDIOVASCULAR HEALTH & CLINICAL HISTORY FORM

To help us better serve you, please provide the following information

Today's date _____	PATIENT INFORMATION		
Last Name: _____	First Name: _____	DOB: _____	
Gender: Male Female	Height: _____	Weight: _____	
Referring Physician: _____			

CARDIAC SYMPTOMS

Description	Yes	No	Activity (Walking/Resting/Any time)	When (Date)
Chest Pain or Pressure				
Palpitations				
Shortness of Breath				
Ankle/Leg Swelling				
Unusual fatigue				
Light-headed/dizziness				
Passing-out episodes				

OTHER SYMPTOMS/MEDICAL HISTORY

Check here if none of the symptoms below apply to you _____

Please circle all that apply to you

- | | |
|------------------------|--|
| Pain on breathing | Emphysema/Asthma (wheezing, inhaling medication) |
| Pneumonia/Tuberculosis | Stroke |
| Arthritis/Gout | Anxiety/Depression |
| Hepatitis | Headaches |
| Broken bones | Thyroid disease |

(PLEASE CIRCLE ALL THAT APPLY TO YOU)

SMOKING	Current smoker _____	Number of packs/day: _____
	Former smoker _____	Date/year stopped: _____

HIGH BLOOD PRESSURE	Controlled with medication _____
	Stopped medication _____
	Poor control with medication _____

HIGH CHOLESTEROL	Controlled with medication _____
	Treated with diet alone _____

