

BAYLOR HEART CLINIC

6620 Main St., Suite 1225, Houston TX 77030 Scheduling: 713.798.2545, Fax: 713.798.2578

CARDIOVASCULAR HEALTH & CLINICAL HISTORY FORM

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

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

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		



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DIABETES MELLITUS	Mild, no diet of medication	
	Treated with diet only	
	Treated with insulin	
	Treated with pills	

FAMILY HISTORY OF HEA	RT DISEASE (Diagnos	sed when less than 55 years old)		
	Mother	Father		
	Brother	Sister		
	Others:			
EXERCISE LEVEL	Regular exe	Regular exercise (walking: fast or slow)		

No reg	ular exercise	

CARDIOVASCULAR HISTORY

PROBLEM/EVENT	NO	WHEN (APPROXIMATE DATE)	WHERE (HOSPITAL OR CITY)
Heart attack			
Heart catheterization (most recent)			
Coronary bypass surgery (CABG)			
Coronary balloon angioplasty/stent			
Valvular implant/replacement			
Congenital heart disease			
Pacemaker implantation			
Defibrillator implantation			
Exercise stress test (treadmill)			
Echocardiogram			
Nuclear stress test			

CURRENT MEDICATIONS

Medication	When was the last dose taken	Usual dose per day