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: _________________________ 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
Pneumonia/Tuberculosis
Arthritis/Gout
Hepatitis
Broken bones
Emphysema/Asthma (wheezing, inhaling medication)
Stroke
Anxiety/Depression
Headaches
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 HEART DISEASE (Diagnosed when less than 55 years old)		
	Mother	Father
	Brother	Sister
	Others: ________________________________	

EXERCISE LEVEL	Regular exercise (walking: fast or slow) No regular 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**