RONALD H. SCHUSTER, M.D., P.A.

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JEFFREY E. SCHREIBER, M.D.

PERSONAL HISTORY EVALUATION

NAME: _____AGE: _____ **DATE: _____**

Chief complaint (What are you being seen for?)

Please list all current medications and dosage:

Please list all allergies:

Please list previous surgery and date:

Do you have or have you had:

High blood pressure	Y/N	Headaches/migraines	Y/N
Heart attack	Y/N	Dizziness	Y/N
Angina/chest pain	Y/N	Seizures	Y/N
Palpitations/arrhythmias	Y/N	Stroke	Y/N
Mitral Valve Prolapse	Y/N	Weakness	Y/N
Rheumatic fever	Y/N	Numbness	Y/N
Heart Surgery	Y/N	Anxiety/nervousness	Y/N
Sinusitis	Y/N	Stomach ulcers	Y/N
Shortness of breath	Y/N	Diarrhea/Constipation	Y/N
Pneumonia/T.B.	Y/N	Hepatitis	Y/N
Bronchitis/Asthma	Y/N	Diabetes	Y/N
Thyroid problems	Y/N	Lupus/arthritis	Y/N
Cancer	Y/N	Problems w/ circulation	Y/N
of what? _____		Problems w/ kidneys	Y/N

Do you have a history of bleeding, hemorrhage, or bruising easily? Y/N

Do you take aspirin regularly? Y/N

Have you ever received a blood transfusion? Y/N If yes, when? _____

Marital status _____ Children _____

Employment _____

Hobbies _____

Do you smoke? Y/N If yes, how much? _____

Family History: