DR. ROBERT PETERSON

Medical Questionnaire

Please answer all questions. Do not leave any blanks.

Y	**N**	Asthma	**Y**	**N**	Phlebitis “blood clots”
Y	**N**	Diabetes	**Y**	**N**	Blood Transfusion
Y	**N**	Migraines	**Y**	**N**	Thyroid disease
Y	**N**	Heart Disease	**Y**	**N**	Wound healing problems
Y	**N**	High Blood Pressure	**Y**	**N**	Anemia
Y	**N**	Epilepsy	**Y**	**N**	Steroids/Prednisone
Y	**N**	Seizures	**Y**	**N**	Stroke
Y	**N**	Kidney Disease	**Y**	**N**	Hepatitis

Y N Diet Pills/Herbal Supplements: Type _____

Y N Mammogram: When _____ Physician _____

Y N MRSA/Staph: When _____ Treatment _____

Y N Pain Medication Dependency: Type _____ Treatment _____

Y N Psychiatric Illnesses: Type _____ Treatment _____

Hospitalization/Surgeries:

Date | Type of Surgery | Place of Surgery | Physician

_____

_____

_____

_____

If more, please list on back of sheet

Family History of:

Please check all that apply:

___ Heart Disease | Relationship _____ ___ Cancer | Relationship _____

___ Diabetes | Relationship _____ ___ Other _____ Relationship _____

Do you:

Smoke **Y N** How much _____ Use Recreational drugs **Y N** Type _____

Use Alcohol **Y N** How often _____ Walk with a walker or cane **Y N**

Current Medications

Over the counter, herbal, nutritional, etc.

Medication Name | Dose | Frequency | Last Dose Taken

_____

_____

If more, please list on back of sheet

Allergies _____

_____