Premier
Wound Care
&
ID Specialist

NEW PATIENT QUESTIONNAIRE/MEDICATION LIST

NAME:	DATE:
Do you use Tobacco? (Yes/No)	Do you use Drugs? (Yes/No)
If Yes, how much?	If Yes, what kind & how much?
Do you use Alcohol? (Yes/No)	Pets? If yes, please list what species below
If YES, how much?	
City, County or Well Water?	

ALLERGIES	TYPE OF REACTION

MEDICINE	WHAT DO YOU TAKE IT FOR	DOSAGE	HOW MANY TIMES A DAY

*continue on back if needed

SURGERIES YOU HAVE HAD	SURGERIES YOU HAVE HAD (cont)

*continue on back if needed

PREFERRED PHARMACY	PHONE NUMBER	ADDRESS
PRIMARY CARE DOCTOR	**PHONE NUMBER**	**ADDRESS**