

WSU Grace Specialty Care

New Patient Information (Please fill out if New to Office)



Medical Information:	
Any Food or Drug Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list all medications	
Are you currently receiving psychiatric/mental health services <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name/address/telephone number	
Past Medical History	
<i>Immunizations</i>	
Are you currently up to date with vaccinations?	
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any History of Sexually Transmitted Infections (STI's) If yes, please list type(s), date(s), Treatment(s)	
Any Hospitalizations? If yes, please list reason, facility, year	
Family History	
Any Family History of: (Family in this instance refers to Mother, Father, Brother, Sister, and Grandparents)	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney/Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Type: _____	
Social Information	
Housing Arrangement	<input type="checkbox"/> Permanent <input type="checkbox"/> Nonpermanent
Transportation	<input type="checkbox"/> Personal <input type="checkbox"/> Public

Education	<input type="checkbox"/> High School	<input type="checkbox"/> College
Imprisonment	<input type="checkbox"/> Yes	<input type="checkbox"/> No Year? _____
Currently Sexually Active	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No Amount? _____
Current Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No Type/Amount? _____
Current Injection Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No Type/Amount? _____
Current Tobacco Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No Amount? _____