

Social History

Make only one selection from the following:

Marital status: Married, Single, Widowed, Divorced, Separated,
Engaged, Relationship with significant other

Children: Yes No
If yes, Sons How many? _____ Ages _____
Daughters How many? _____ Ages _____

Health of spouse or significant other: Good Poor

Are you sexually active? Yes No

Have you had a history of Sexually Transmitted Diseases? Yes No
If yes, type _____

Do you smoke? Yes No If yes, number of packs per day _____

When did you start smoking? Age _____

Have you ever smoked in the past? Yes No
If yes, age started _____ age stopped _____

Alcohol consumption? Yes No Number per day _____ Number per week _____

Select Type: Beer, Wine, Distilled spirits, Moonshine

Ever had a drinking problem? Yes No

Ever had a drug problem? Yes No

Ever used intravenous drugs? Yes No If yes, date last used _____

Occupation: _____

Is your job a risk to your health? Yes No

Name _____ Date of Birth _____