

# SOCIAL HISTORY

Please Complete Front and Back

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Franklin County Memorial Hospital and Rural Health Clinics requests that you complete this form. Please complete the following Social History questions to help us better serve you and your healthcare needs. This form will be filled out one time and then updated each visit on the computer. As a part of requirements for electronic medical records the Federal Government requires that we ask you to complete a social profile.

All answers are confidential, however if you do not wish to answer a question please feel free to leave it blank. Please check the box next to your answer and fill in the blank where appropriate. Thank you for your time.

## 1 Tobacco Use

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chew Tobacco     | <input type="checkbox"/> Cigar Smoker               | <input type="checkbox"/> Not planning on quitting    |
| <input type="checkbox"/> Snuff User       | <input type="checkbox"/> Pipe Smoker                | <input type="checkbox"/> Thinking about quitting     |
| <input type="checkbox"/> Passive Smoker   | <input type="checkbox"/> Exposed to Tobacco at home | <input type="checkbox"/> Looking for options to quit |
| <input type="checkbox"/> Cigarette Smoker | <input type="checkbox"/> Light Tobacco User         | <input type="checkbox"/> Other (please specify)      |

### 1a Smoking Status

- |   |   |
|---|---|
| <input type="checkbox"/> Never a smoker           | <input type="checkbox"/> Heavy Tobacco Smoker                           |
| <input type="checkbox"/> Former smoker            | <input type="checkbox"/> Smoker ( <i>Current status unknown</i> )       |
| <input type="checkbox"/> Light Tobacco Smoker     | <input type="checkbox"/> Current ( <i>Social or occasional smoker</i> ) |
| <input type="checkbox"/> Current Every-Day Smoker | <input type="checkbox"/> Unknown if ever a smoker                       |

1b Smokless Tobacco **Have you used smokeless tobacco in the last 30 days?** Yes  No

### 2a Drinking Alcohol **How often do you drink beer, wine or liquor?**

- |  |  |
|--|--|
| <input type="checkbox"/> Never                           | <input type="checkbox"/> On the Weekend                    |
| <input type="checkbox"/> On Holidays / Special Occasions | <input type="checkbox"/> 2-3 Times per Week                |
| <input type="checkbox"/> Once a Month or Less            | <input type="checkbox"/> Daily After work to relax / sleep |

### 2a Drinking Status **How often do you drink 6 or more drinks containing alcohol on one occasion?**

- Never  Monthly  Weekends  2-3 Times / Week  Daily or After Work

**Do you use "street drugs?" (*marijuana, cocaine, methamphetamines, non-Rx drugs*)**

3 Street Drugs  Yes  No

3a Street Drugs Use  Never  Monthly  Weekends  2-3 Times / Week  Daily or After Work

### 3b Drugs Use **Do you find it difficult to get through a week without using drugs?**

Issues

- Yes  No

### 3c **How hard is it for you to pay for the very basics like food, housing, medical care, and heating?**

- Not Very Hard  Somewhat Hard  Hard  Very Hard

4 Highest Level of Education \_\_\_\_\_

5. Stress is a situation that causes a person to feel; tense, restless, nervous, anxious, and can cause sleep disturbances or other problems. How often do you feel this type of stress?

- Never  Monthly  Weekends  2-3 Times / Week  Daily or After Work

6. In the last two weeks, have you lost interest in any of your normal activities?

- Never  Once  A Few Days  Most of the Time  All of the Time

7. In the last two weeks, have you experienced feelings of sadness, hopelessness or depression?

- Never  Once  A Few Days  Most of the Time  All of the Time

8. Within the last year, have you been humiliated or emotionally abused in any way by your partner?

- Yes  No

9. Within the last year, have you been afraid of your partner, or ex-partner?

- Yes  No

10. Within the last year, have you been raped, or forced to have sexual contact by your partner or ex?

- Yes  No

11. Within the last year, have you been kicked, hit, slapped or otherwise physically harmed by your partner or ex?

- Yes  No