**Reproductive Health Clinic**

**Social History**

Date ________________

Name______________________________DOB________________

People you live with: Name Relationship Age

1. ____________________________ __________ ___
2. ____________________________ __________ ___
3. ____________________________ __________ ___
4. ____________________________ __________ ___
5. ____________________________ __________ ___
6. ____________________________ __________ ___

Last Grade Completed:________GED/Diploma_________

Do you have any problems with any of the following:

Housing __yes__no

Food __yes__no

Transportation __yes__no

Employment __yes__no

Other___________________________________

Are/have you ever seen a counselor or social worker to help you with any problems?_____

Do you have any problems now that are worrying you?____

Do you have a support system?____

Health Matters

1. Have you ever been pregnant___
2. Do you have any children?___
3. Do you smoke cigarettes?___ marijuana?___
4. Do you use “hard drugs”?___
5. Do you drink beer, wine or other alcohol?___
6. Do you have a problem with depression?___
7. Have you ever tried to commit suicide?___
8. Have you ever had a sexually transmitted disease (STD)?

Family Matters

1. Does your spouse/partner know that you have come to the clinic?___
2. If you live with your parents, do they know you have come to the clinic?___
3. Are there any problems in the way you get along with your family?___
4. Have you ever lived in a foster home?___
5. Have any of your children ever been placed in a foster home, a group home, an institution, or adopted?___

Thank you for answering the questionnaire. All of your answers are confidential.