OPIOD ABUSE HISTORY QUESTIONAIRE

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_____ _____
Today's Date **Drug Allergies**

NAME: _____
Last **First** **Middle**

Address:_____

Home Phone_____**Cell Phone**_____

Age_____**Date of Birth**_____

Marital Status_____**Height**_____**Weight**_____

Occupation:_____**E-Mail**_____

Company/School_____

Work Phone_____**Social Security #**_____
(For Office Use only)

Wife/Husband/ Significant Other's Name_____

Age_____**Occupation**_____

Cell Phone #_____**Work Phone #**_____

Mother's Name_____**Age**_____**Occupation**_____

Cell Phone #_____**Work Phone #**_____

Father's Name__**_____**_____**Age**____**Occupation**_____

Cell Phone #_____**Work Phone #**_____

Children (Include names, ages/marital status/occupation/grandchildren)_____

_____

_____

Siblings (Include names, ages/marital status/occupation/nieces or nephews)_____

_____

_____

Please list referral source:

_____ _____

Referral Source **Phone Number of Referral Source**

EMERGENCY CONTACT

Name_____**Relationship to you**_____

Daytime Phone: _____**Cell Phone**_____

Evening Phone_____

Opioid of Choice: _____

How taken ?eg. Oral, inhaled, injected): _____

Current Number of Times per Day Used: _____

Current Amount Spent per Use: _____

Last Use (Date and Time): _____

Present Symptoms: _____

_____

_____

Have you ever overdosed either intentionally or unintentionally on any drug?

Yes _____ **No** _____ **If yes, give details including date(s), drug(s),**

treatment and location of treatment. _____

_____

_____

History of Drug Abuse Treatment: _____

_____

_____

_____

Please describe your relapses (if you've had relapses). Include information on

What triggered the relapse, drugs associated with relapse, etc. _____

_____

Are you currently receiving counseling or therapy for your addiction?

Yes _____ No _____ If yes, for how long, where and with whom _____

_____

Do you attend any 12-Step Recovery Programs? Yes _____ No _____

If yes, which one(s) and how frequently _____

_____

Have you experienced withdrawal? Yes _____ No _____

Describe your withdrawal symptoms _____

_____

Do you have a family history of addiction (drugs or alcohol)? Yes_____ No_____

If yes, please give details: _____

_____

Why are you seeking treatment for your addiction at this time? _____

_____

_____

_____

_____

Have you been ordered by the courts or your employer to attend a treatment

program? Yes _____ No _____

Are your currently employed? Yes _____ No _____ If yes, what do you do? _____

Is anyone aware of your addiction problem? Yes _____ No _____

Are they supportive of you seeking treatment? _____
_____

MEDICAL HISTORY

Primary Physician's Name: _____
Physician's Phone No.: _____
Doctor's Address: _____
Date of most recent physical examination: _____

Have you ever been treated for any of the following?

	YES	NO	COMMENTS
Heart Disease			
High Blood Pressure			
Stroke			
Diabetes			
Arthritis			
Parkinson's			
Cataracts/other eye problems			
Glaucoma			
Hearing Problems			
Lung Disease			
Skin Diseases			
Urinary Tract Infections			
Gastro-Intestinal			
Growths / Cancer			
Hospitalizations			
Major Operations			
Sexually Transmitted Diseases			
Kidney Disease			
Liver Disease			
Gynecologic Problems			
Psychiatric Disorders			
Other Medical Problems			

Have you had?

Blackouts			
Convulsions or Seizures			
Headaches			
Tremors			
Dizziness			
Forgetfulness			
Major Weight Loss/ Gain			

Do you have a history of:

Drug Abuse
Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Has anyone in your family been treated for?

	YES	NO	COMMENTS
Heart Disease			
High Blood Pressure			
Stroke			
Diabetes			
Arthritis			
Parkinson's			
Cataracts/other eye problems			
Glaucoma			
Hearing Problems			
Lung Disease			
Skin Diseases			
Urinary Tract Infections			
Gastro-Intestinal			
Growths / Cancer			
Hospitalizations			
Major Operations			
Sexually Transmitted Diseases			
Kidney Disease			
Liver Disease			
Gynecologic Problems			
Psychiatric Disorders			
Other Medical Problems			

Has anyone in your family had?

Blackouts			
Convulsions or Seizures			
Headaches			
Tremors			
Dizziness			
Forgetfulness			
Major Weight Loss/ Gain			

Does anyone in your family have a history of :

Drug Abuse			
Alcohol Abuse			

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Additional Medical History

Allergies: _____
Current medications (include over the counter medications):
_____
_____
_____

Medical /Psychiatric Problems: _____
_____
Have you ever tried to commit suicide? Yes _____ No _____

What are your reasons for being interested in Buprenorphine treatment?
_____
_____
_____
_____
_____
Are you currently using any illicit drugs or alcohol? If so, what are you using?
_____
_____

If you are not currently using drugs or alcohol, when was the last time you relapsed to use?
_____

What "triggers" do you know which have put you in danger of relapse in the past, or which might in the future? _____

What coping methods have you developed to deal with these triggers to relapse?

Are there any special plans (such as major trips) that you have for the coming year?
Work _____
Home _____
Other _____

Are there any significant medical events (such as surgery) that you expect you will need in the coming year? _____
_____
_____
_____

What kinds of counseling or therapy are you currently receiving for your drug

abuse problem? _____

_____

_____

What are your strengths and skills to handle take-home Buprenorphine?

_____

_____

What worries do you have about being responsible for taking this medication on your own at home? _____

_____

Is anyone in your home actively addicted to drugs or alcohol?

_____

What are the major sources of stress in your life?

_____

_____

_____

_____

Are there any issues that you would particularly like to discuss with the doctor?

_____

_____

_____