



SUBOXONE PROGRAM

Patient Intake: Medical History

(To be completed by patient)

Use the opposite side of page as necessary to complete your answers. **Please print legibly.**

Name: _____

Address: _____

Phone (w): _____ (h) _____ (c) _____

DOB: _____ Age: _____ SS#: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of last physical: _____ Have you ever had an EKG? No Yes Date: _____

Current or past medical conditions. (Check all that apply):

IF there is a family history of any of the illnesses below, **please put an "F" next to the illness**

- | | | |
|---------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Asthma/Respiratory | <input type="checkbox"/> Cardiovascular (heart attack, high cholesterol, angina) | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> GI disease |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Pancreatic problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> STD's | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Nutritional deficiency |

Other (please describe): _____

Family History of Illness not listed above? (Please explain): Use back side of paper



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Have you ever had **surgery** or been **hospitalized**? (Please describe): _____

Childhood Illnesses:

Measles Yes No Mumps Yes No Chicken Pox Yes No

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**?
(Please describe): _____

Have you ever taken or been prescribed **antidepressants**? No Yes For what reason?

Medication(s) and dates of use: _____
Why did you stop? _____

Please list all current **prescription medications** and how often you take them (example:
Dilantin 3x/day) **DO NOT** include medication you may be currently misusing (that information
will be covered later)

Please list all **current herbal medicines, vitamin supplements**, etc. and how often you take
them.

Physician Notes:

Please list any **allergies** you have (penicillin, bees, peanuts, etc.):



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Tobacco History

Cigarettes: Now? No Yes
 How many per day on average? _____

In the past? No Yes
 For how many years? _____

Pipe: Now? No Yes
 How often per day on average? _____

In the past? No Yes
 For how many years? _____

Have you ever been treated for substance misuse? No
 (If YES, please describe when, where and for how long) _____

How long have you been using substances? _____

Substance Abuse History

	No	Yes/Past Or Yes/Now	Route	How Much	How Often	Date/Time of last Use	Quantity last used
Alcohol							
Caffeine (pills or beverage)							
Cocaine							
Crystal Meth- Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/Sleeping Pills							
Ecstasy							
Other							



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Did you ever stop using any of the above because of dependence? No Yes (Please list):

What was your longest period of abstinence? _____

Physician Notes: _____
