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**

□ Asthma/Respiratory	□ Cardiovascular (heart attack, high cholesterol, angina)	
□ Hypertension	□ Epilepsy or seizure disorder	□ GI disease
□ Head Trauma	□ HIV/AIDS	□ Diabetes
□ Liver Problems	□ Pancreatic problems	□ Thyroid Disease
□ STD's	□ Abnormal Pap smear	□ 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 In the past? □ No □ Yes
How many per day on average? __________ For how many years? __________

Pipe: Now? □ No □ Yes In the past? □ No □ Yes
How often per day on average? __________ 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							

SUBOXONE PROGRAM

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: ____

____

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