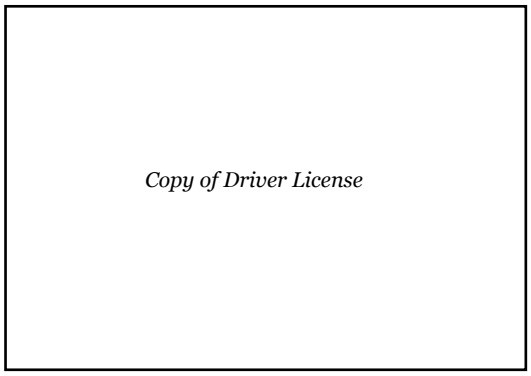
Medical History



Name: _____ Date: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____ Phone: _____ Phone: _____

Date of Birth: _____ Age: _____ SSN: _____

Email: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Primary Care Physician

Name: _____

Address: _____

Phone: _____

Previous Medical History

- Ear, Nose or Throat Problems _____
- Head Trauma _____
- High Blood Pressure _____
- Hepatitis or other Liver Problems _____
- Sexually Transmitted Disease _____
- HIV/AIDS _____
- Asthma _____
- COPD _____
- Other Respiratory Problems _____
- Heart Problems _____
- Other Cardiovascular Issues _____
- Blood Clots _____
- Cancer _____
- Epilepsy or Seizures _____
- Stomach Ulcers _____
- Other Gastro-Intestinal Disorders _____
- Thyroid Disease _____
- Diabetes _____
- Pancreatic Disease_____
- Abnormal Pap Smear_____
- Nutritional Deficiency _____
- Glaucoma _____
- Other Eye Disorders _____
- Hearing Impairment _____
- Unexplained Weight Loss _____
- Prostate Problems _____

- High Cholesterol or Triglycerides _____
- Arthritis _____
- Chronic Pain Syndrome _____
- Back Pain _____
- Migraine Headaches _____
- Joint pain not related to Arthritis _____
- Other (Mental Illness, Anxiety, Depression) _____

When was your last check-up with your Family Physician (including routine blood work and/or urinalysis? _____

How often do you see your Family Physician? _____

Have you had a recent EKG or Chest X-Ray? Yes No

Family History

- Ear, Nose or Throat Problems_____
- Asthma or COPD _____
- Respiratory Problems _____
- Heart Attack or Stroke _____
- Blood Clots _____
- Cancer _____
- Stomach Ulcer _____
- Pancreatitis _____
- Ulcerative Colitis _____
- Hepatitis _____
- HIV/AIDS _____
- Addictive Disorders _____
- Crohn's Disease _____
- Diabetes _____

- High Blood Pressure _____
- Dementia _____
- Peripheral Vascular Disease _____
- Epilepsy _____
- Thyroid Disease _____
- Other (Anxiety, Depression, Mental Illness) _____

Previous Surgical History

- Appendectomy _____
- Tonsillectomy _____
- Gall Bladder _____
- Abdominal Surgery _____
- Orthopedic Surgery (Broken Bones) _____
- Neurosurgery (Back or Brain) _____
- Vascular Surgery _____
- Thoracic Surgery _____
- Hand or Foot Surgery _____
- Recent Hospitalizations _____

Other _____

_____

_____

_____

Childhood Illnesses

- Mumps
- Measles
- Rubella
- Whooping Cough

- Chicken Pox
- Other _____

Immunization History

- Did you receive required childhood immunizations? _____
- Hepatitis _____
- Tetanus _____
- Meningitis _____
- Other _____

_____

_____

Medication History

Please list current ***prescription*** medication including name, strength and directions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list current ***NON-prescription*** medications including illegal drugs, herbs and vitamins:

1. _____
2. _____

3. _____
4. _____
5. _____
6. _____

Allergies

1. _____
2. _____
3. _____
4. _____
5. _____

Tobacco History (How much and how long)

1. Cigarettes _____
2. Cigars _____
3. E-Cigarettes _____
4. Chewing Tobacco _____
5. Smokeless Tobacco _____

Substance Misuse (How much and how long)

- Heroin _____
- Hydrocodone _____
- Oxycodone _____
- Codeine _____
- Methamphetamine _____
- Cocaine _____
- Marijuana _____
- Benzodiazepines (Xanax, Valium) _____
- Other _____

Treatment Center (Where and when)

_____

_____

_____

Did you ever stop using any substance because of dependence?

- Yes
- No

What was you longest period of abstinence? _____

Social History

1. Are you married? Yes No
2. Are you divorced or separated? Yes No
3. Do you have children? Yes No
4. How many times have you been married? _____
5. Where do you reside? _____
6. Who lives with you? _____
7. Do you have family nearby? _____
8. What level of education did you achieve? _____
9. Are you employed? Yes No
10. What type of work do you do? _____
11. How long have you worked there? _____
12. Have you ever been arrested or convicted? _____
13. Have you ever had a DUI, drug or domestic violence arrest? Yes No
14. Have you ever attended AA, NA or been treated at a Medically-assisted treatment (MAT) program? Yes No
15. Have you ever been physically, sexually, verbally or emotionally abused? Yes No
16. Have you ever been in counseling or therapy? Yes No

Dear Patient,

Thank you for taking the time to complete this rather lengthy questionnaire. Let me assure you that all of the information you have been so kind to provide is completely confidential. I also want you to know that we care deeply about you and we shall strive to provide the quality of care that you so richly deserve. Genuine compassion is at the heart of our clinic. When you visit us, you will find a warm and inviting atmosphere. We are here to serve YOU and see to your needs. We shall do our best to answer any, and all, questions you may have regarding your well-being. I am committed to good health through good choices. We both must work hard and stay focused on our goals. Together we can make good things happen. I look forward to seeing you and commencing a journey to a better life.

With warmest regards,

Dr. Randy Nance
Certified Buprenorphine Physician (Department of Health and Human Services)