Fireweed Health Care, Inc.

3500 LaTouche Street, Suite 240A | Anchorage, AK 99508 | Phone (907) 276-4611 | FAX (907) 258-5167

F/U OUD Questionnaire

Name_____ Date_____

Any new allergies since last visit? ☐ Yes ☐ No **Any medication changes?** ☐ Yes ☐ No

Medication-Assisted Treatment (MAT) Progress:
When did you take your last dose of medication? _____ How much is left? _____

Any cravings for opioids? ☐ Yes ☐ No Any withdrawal symptoms? ☐ Yes ☐ No

Have you relapsed on opioids since your last visit? ☐ Yes ☐ No

If yes, what did you use? _____

What will be in your urine today? _____

Would you like urine STI testing today? (chlamydia/gonorrhea) ☐ Yes ☐ No Pregnancy Testing? ☐ Yes ☐ No

Recovery Groups, Counseling and Peer Support:
Have you attended AA/NA or another recovery group meeting since your last visit? ☐ Yes ☐ No

Have you participated in a counseling session since your last visit? ☐ Yes ☐ No

Have you spent time with your support network since your last visit? ☐ Yes ☐ No

Employment and Shelter:
I am unemployed. ☐ Yes ☐ No Are you seeking work? ☐ Yes ☐ No

I am employed at _____ for _____ hours/week.

Are you sheltered? ☐ Yes No Do you need assistance finding/arranging housing? ☐ Yes ☐ No

Nicotine and Alcohol Use:
Do you use nicotine? ☐ Yes ☐ No In what form? _____

Average daily amount: _____ Would you like help quitting? ☐ Yes ☐ No

Any alcohol use since your last visit? ☐ Yes ☐ No If yes, please explain: _____

Medical Concerns:
Have you ever had a seizure? ☐ Yes ☐ No When was your last seizure? _____

How is your sleep?: ☐ Good ☐ Fair ☐ Poor # of hours nightly _____

How often do you have a bowel movement? ☐ Daily ☐ Every other day ☐ 2x/week ☐ weekly

Any difficulty urinating? ☐ Yes ☐ No Any nausea or vomiting? ☐ Yes ☐ No

Any sores that are red, painful, or with drainage that you would like me to evaluate today? ☐ Yes ☐ No

Any chest pain since your last visit? ☐ Yes ☐ No Any trouble breathing? ☐ Yes ☐ No

Are you feeling suicidal? ☐ Yes ☐ No If you are female, are you pregnant? ☐ Yes ☐ No