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F/U OUD Questionnaire

Name____ Date___________________

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

Current weight: ____________

Do you use nicotine? ▢ Yes ▢ No In what form? _______________________________________

Average daily amount: ______________________ Would you like help quitting? ▢ Yes ▢ No

When did you take your last dose of medication? ________________ How much is left? __________

Any side effects from your medicine? ▢ Yes ▢ No What are they? _________________________

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

Relapse since last visit? ▢ Yes ▢ No When/What did you use? ____________________________

What will be in your urine today? ____

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

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

Do you want help finding drug counseling or mental health services? ▢ Yes ▢ No

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

I am employed at ______________________________________ for ____________ hours/week

I am unemployed. ▢ Yes ▢ No Are you seeking work? ▢ Yes ▢ No

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

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

Are you constipated? ▢ Yes ▢ No Difficulty urinating? ▢ Yes ▢ No Nausea/Vomiting? ▢ Yes ▢ No

Have you ever had a seizure? ▢ Yes ▢ No When was your last seizure? _____________________

If you are female, are you pregnant? ▢ Yes ▢ No Are you using birth control? ▢ Yes ▢ No

How is your sleep?: ▢ Good ▢ Fair ▢ Poor # of hours nightly ______________________

Any chest pain since last visit? ▢ Yes ▢ No Shortness of breath or difficulty breathing? ▢ Yes ▢ No

Are you feeling suicidal? ▢ Yes ▢ No

Are there any medical issues that you would like me to evaluate today? ▢ Yes ▢ No

Would you like Chlamydia/Gonorrhea testing today? ▢ Yes ▢ No Pregnancy testing? ▢ Yes ▢ No