Fireweed Health Care
OUD F/U Visit Questionnaire

Name_____ **Date**_____

Drug Allergies & reaction: _____

My **bowel movements** are: REGULAR CONSTIPATED DIARRHEA
My BM's are: Daily Every other day 2x/week Every 5-6 days Weekly
Is this a normal frequency for you? Yes No

If female, are you **pregnant**? Yes No If you become pregnant, please notify us immediately.

Do you use **nicotine**? Yes No If yes, how much on average daily? _____
Would you like help with quitting? Yes No
Any use of alcohol since your last visit? Yes No

How is your **sleep**? Good Fair Poor Average hours of sleep per 24 hours? _____
Are you currently **working**? Yes No How many hours per week? _____
Are you currently **attending school**? Yes No

Global/Withdrawal: Are you experiencing any of the following? (circle all that apply)
Anxious Yawning Sweating Teary eyes Runny nose
Goosebumps Shaking/tremors Hot flushes Cold flashes Achy bones & muscles
Restless Nauseated Vomiting Muscles twitching Stomach cramps

Discussion:
Since your last visit, any **ER/urgent care or other provider visits**? Yes No
Since your last visit, have there been **changes in any of your medications**? Yes No

Are there any **new medical issues** or unresolved **psychiatric issues** such as anxiety, depression or bi-polar or any **new social stressors** which you would like to review with the provider today? Yes No

Progress:
Are you experiencing any **side effects** from your medication? Yes No
Are you experiencing cravings for opioids? Yes No
Have you experienced a relapse on opioids since your last visit? Yes No
Will a UA collected today show any unprescribed substances? Yes No
Have you attended AA/NA or other 12-step program since your last visit? Yes No
Have you attended a therapy session since your last visit, i.e. counseling or group therapy? Yes No
Have you spent time with your support network since your last visit? Yes No