North Canyon
MEDICAL CENTER

North Canyon Family Medicine Clinic

Opiate and Other Substance Use Questionnaire

When was your very first use (dose) of an opiate? _____

What was the reason? (Please check one): Experimental ___ Recreational ___ Pain Management ___ (prescribed), Pain Management ___ (not prescribed).

What opiate did you first take? (Circle one): Hydrocodone, Oxycodone, Heroin, Fentanyl, Methadone.

Other: _____Describe: _____

Which opiates have you used regularly? _____

How many years have you taken opiates? _____

Did you ever have a period of time when you were able to stop taking opiates? (Circle one): Yes / No

What is the longest period of abstinence you have had? _____months/yrs.

What routes of administration have you used? (Please check one): Oral___ Inhalation ___ Injection IV ___

In the space below please list and describe any other controlled substances you have used, including alcohol.

Use of any controlled substances (prescribed or illicit) other than Suboxone such as Benzodiazepines, stimulants (other than nicotine or caffeine), alcohol, marijuana, and cocaine use is prohibited while receiving prescribed Suboxone.

Please be honest in your answers, this information is vital medical history for the Provider.

1) Substance ***(Alcohol):*** _____Last used: _____
   Amount: _____ Route of Administration (Oral): _____
   How often: _____ How long: _____
   Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
   Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

2) Substance:_____ Last used: _____
   Amount: _____ Route of Administration: _____
   How often: _____ How long: _____
   Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
   Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

3) Substance:_____ Last used: _____
   Amount: _____ Route of Administration: _____
   How often: _____ How long: _____
   Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
   Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

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4) Substance:_____ Last used: _____
Amount: _____ Route of Administration: _____
How often: _____ How long: _____
Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

5) Substance:_____ Last used: _____
Amount: _____ Route of Administration: _____
How often: _____ How long: _____
Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

6) Substance:_____ Last used: _____
Amount: _____ Route of Administration: _____
How often: _____ How long: _____
Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

7) Substance:_____ Last used: _____
Amount: _____ Route of Administration: _____
How often: _____ How long: _____
Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

8) Substance:_____ Last used: _____
Amount: _____ Route of Administration: _____
How often: _____ How long: _____
Have you or anyone else thought that you had a problem with this substance? **Yes** / **No**
Have you ever had a period of abstinence from this? **Yes** / **No** If so, how long?_____

Patient Name (Please Print): _____ Date: _____

Patient Signature: _____

***Please note that random drug screening will be required at the discretion of your Provider, see MAT Program Contract for details. ***