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/hrs.

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?____________________________
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. **