WESTBROOK MEDICAL CENTER

7328 MIDDLEBROOK PIKE
KNOXVILLE, TN 37909
(865) 769-2600

BUPRENORPHINE TREATMENT

Admission history and physical examination form

Name: _____ **Date:**___/___/___

Date of birth:___/___/___ **Age:**_____ **Sex:** M / F

Height/Weight_____ **B/P**_____ **P**_____ **R**_____ **T**_____ **O2**_____

Hospitalization, surgeries: list date, hospital and reason.

_____

_____

Do you have any of the following?

HTN	Liver Disease/Hepatitis
Heart Disease	Diabetes
Asthma	Thyroid Disease
HIV/AIDS	Cancer
Mental Illness	Hx of Seizures

Medications (include OTC): _____

_____

_____

Allergies: _____

Prior Drug TX: When - Where

_____

_____

Drug Overdose: _____

Family History (only immediate family) If deceased, give age and cause of death:

Heart disease	Diabetes
HTN	Alcohol/Drug abuse
Mental Illness	Cancer

Substance Use History:

Heroin _____/day _____days/wk. I.V. I.N. How long _____
Other opiates _____
_____/day _____days/wk. P.O. I.V. I.N. How long_____
Cocaine _____/day _____days/wk. I.V. I.N. Smoke Last use_____
Alcohol_____Type Amt_____/day _____days/wk. Current: y n
Benzodiazep. _____ Drug & amt._____/day ____days/wk. Current: y n
Marijuana_____/day _____days/wk. How long_____
Tobacco_____pack/can(s)/day Current: yes no, quit date_____

Patient's Name _____

Other:(clonidine, phenergan, other sedatives, PCP, LSD, amphetamines, inhalants)
_____
_____

Last substance used :(what, when, amount)
_____

Social History:
Currently working: yes no
Type (present or previous work):_____
Healthcare: yes no where:_____
last visit:_____ reason for visit:_____
Marital status:_____ Lives with:_____
Does spouse or partner use drugs?_____
Children :(ages)_____
Children live with:_____

OB/Gyn:
Last menstrual period:_____ Interval:_____
Flow: Normal Heavy scant Abnormal discharge n / y _____
times pregnant:_____ # deliveries_____
Breast: c/o Pain_____ Lump_____ Discharge_____
Last Pap smear:_____Result: Normal Abnormal_____

Review of Systems: √ if pos.
General: Weight change___, Loss of appetite___, Fever___, Night sweats___, Fatigue___.
Immunol./Integ.: Swollen "glands"___, Skin rash___, Abscess___, Tracks___.
EENT: Poor vision___, Poor hearing___, Dental problems___, Hoarseness___.
Pulmonary: Cough___, Wheezing___, Shortness of breath___.
Circulatory: Chest pain___, Fainting___, Palpitations___, Ankle swelling___, Cold or painful extremity___.
Gastrointest.: Heartburn___, Abdominal pain___, N / V / D / C Hemorrhoids___.
Urogenital: Nocturia x ___, Urgency/freq.___, Hematuria___, Discharge___, Decreased Libido___, Irregular Periods___, Amenorrhea___.
Musculoskeletal: Back pain___, Joint pain___, Joint swelling___, Muscle weakness___.
Neurologic: Headache___, Memory loss__, Incoordination___, Depression___, Anxiety___.

Labs reviewed with patient today:_____
Comments:_____
_____
_____

Office-based maintenance assessment:
_____ Opioid dependence/addiction
_____ Patient in withdrawal: degree_____
_____ admit to Buprenorphine treatment
Initial dose order:_____ time given:_____
Subsequent doses:_____ time given:_____
Subsequent doses:_____ time given:_____
Subsequent doses:_____ time given:_____

Patient's Name _____

Diagnoses:

1. _____
2. _____
3. _____
4. _____
5. _____

Problem List / Treatment Plan:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

Medications prescribed this visit:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Additional notes_____

_____

_____

_____

_____

_____

Physician's signature_____ ***Date***_____