REPLACEMENT NARCOTIC THERAPY ADMISSION

Patient Health History Section

Patient Name: _____ Admit Date: _____

A. Personal Health History:

If you have or previously had any of the following problems listed below, please check the box to the left of it:

Head	Eye	Nose	Throat / Neck	Ear
☐ Headache	☐ Cataract	☐ Nose bleeds	☐ Difficulty swallowing	☐ Earache / Discharge
☐ Sinus pain	☐ Impaired Vision	☐ Obstruction	☐ Hoarseness	☐ Impaired Hearing
☐ Other:	☐ Glasses	☐ Postnasal drip	☐ Persistent cough	☐ Tinnitus / Ringing in ears
	☐ Glaucoma	☐ Sinus Problems	☐ Sore throat	☐ Other:
	☐ Other:	☐ Other:	☐ Tonsillitis	
			☐ Other:	

Mouth	Pulmonary-Respiratory	Cardiovascular
☐ Gum Problems	☐ Asthma	☐ Aneurysm
☐ Lip Problems	☐ Chronic Cough	☐ Chest Pain
☐ Speech Defect	☐ Coughing Up Blood	☐ High Cholesterol
☐ Teeth Problems	☐ Emphysema	☐ High/Low Blood Pressure
☐ Tongue Problems	☐ Pneumonia	☐ Heart Disease
☐ Other:	☐ Shortness of Breath	☐ Hyperlipidemia
	☐ Sleep Apnea	☐ Irregular Heart Beat
	☐ Tuberculosis	☐ Poor Circulation
	☐ Other:	☐ Stroke
		☐ Other:

Gastro-Intestinal		Genito-Urinary	Endo-Hematological
☐ Bloating	☐ Rectal/stool bleeding	☐ Blood in Urine	☐ Anemia
☐ Change in bowel movement	☐ Ulcers	☐ Enlarged Prostate	☐ Arterial Sclerotic Disorder
☐ Cirrhosis	☐ Weight Disorders	☐ Frequent Urination	☐ Bleeding disorder
☐ Constipation	☐ Other:	☐ Kidney Stones	☐ Diabetes
☐ Diarrhea		☐ Lack of Bladder Control	☐ Enlarged glands
☐ Digestive Disorders		☐ Painful Urination	☐ Hormone Imbalance
☐ Heartburn or indigestion		☐ STDs	☐ Hyperthyroid
☐ Hemorroids		☐ Other:	☐ Past transfusion
☐ Hepatitis			☐ Thyroid Problems
☐ Nausea or vomiting			☐ Other:

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REPLACEMENT NARCOTIC THERAPY ADMISSION

Patient Health History Section

Neuro-Psych	Skeleton-Muscular	Skin / Hair / Nails
☐ Anorexia	☐ Arthritis / Joint Pain	☐ Abscesses
☐ Alzheimers	☐ Deformities	☐ Change in moles
☐ Blackouts	☐ Hernia	☐ Inflamation
☐ Dizziness	☐ Herniated Disks	☐ Itching / Rash
☐ Epilepsy	☐ Muscle Weakness	☐ Loss of hair
☐ Fainting	☐ Muscular Dystrophy	☐ Psoriasis
☐ Fatigue	☐ Neuralgia	☐ Sore/Bruises that won't heal
☐ Migraines	☐ Neuritis	☐ Swelling
☐ Multiple Sclerosis	☐ Paralysis / Physical disability	
☐ Numbness in extremities	☐ Twitching	
☐ Parkinson's Disease	☐ Osteoporosis	
☐ Suicide Attempts		

B. Family History (first degree relatives only)

☐ Alcohol or drug problem	☐ Cancer	☐ Heart Disease	☐ Rheumatism
☐ Allergies	Cancer Type:_____	☐ High Cholesterol	☐ Sleeping Disorders
☐ Arthritis / Joint Pain	☐ Colitis	☐ High/Low Blood Pressure	☐ Stroke / Aneurysm
☐ Alzheimers	☐ Diabetes	☐ Kidney / Liver Disease	☐ Tuberculosis
☐ Anemia	☐ Emphysema	☐ Mental Illness	☐ Weight Disorders
☐ Asthma	☐ Epilepsy	☐ Migraine	☐ Other

If deceased give age and cause of death:

	Age	Cause		Age	Cause
Father:	_____	_____	Mother:	_____	_____
Brothers:	_____	_____	Sisters:	_____	_____
	_____	_____		_____	_____

C. Female Health History

1. Date past periods begin? _____
2. Age menses begin? _____
3. Number of pregnancies? _____
4. Number of miscarriages? _____
5. Date of last pregnancy? _____
6. Date of menopause? _____
7. Vaginal discharge:? _____
8. Pelvic pain? _____
9. Infertility? ☐ Yes ☐ No
10. Character of Menses: _____
    a. Length of flow? _____
    b. How often? ☐ Regular ☐ Irregular ☐ Heavy ☐ Light ☐ Cramps

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