FOLLOW UP VISIT FOR SUBOXONE

Please Print
Today's date: _____

Name: _____ DOB: _____

SYMPTOMS (please circle one)
Stable Worse Improved Unchanged

Have you had any cravings? (please circle)
NO YES (explain)
_____

Since your last visit have you relapsed? (if yes please specify which substance and when)
NO YES (explain)
_____

Have you attended any AA/NA meetings since your last visit?
NO YES (dates and location)
_____
_____

Have you established a support network? (family, non-drug using friends, spouse, significant other, etc.)
NO YES (who)
_____
_____

Medication Changes (please circle)
Any medication changes? YES NO (if yes please list changes below)

List all changes:

Name	Dose(msg,mcg)	Frequency (per day)	Prescribing Doctor

Side Effects/Symptoms (please circle all that apply)

Fever	Sedation (sleepiness)
Chills	Fluttering of the heart
Constipation	Abdominal pain
Nausea	Double/Blurred vision
Dizziness	Sweats