

Substance Use History and Physical Examination



Name _____ Age _____

Height _____ Weight _____ BAC (if known/applicable) _____

I. Past Medical History

Have you ever been told that you had:

Gastritis _____ Hepatitis _____

Pancreatitis _____ Cirrhosis _____

Abnormal liver tests _____ Diabetes _____

High blood pressure _____ Delirium tremens" _____

Gout _____ Anemia _____

Do you use tranquilizers _____ Sedatives _____

Do you smoke _____ History: Packs/day _____ Pack Years _____

Comments _____

II. Family History

High blood pressure _____ Alcohol dependence/ drug dependence _____

Diabetes _____ Mother ___ / ___ Father ___ / ___

Liver Disease _____ Siblings ___ / ___ Aunts/Uncles ___ / ___

Grandparents ___ / ___

Comments _____

III. Social History

Occupation _____ Marital Status _____

Lives with whom _____

Children? _____

IV. Review of Systems

	Yes	No	Explain
Fatigue	___	___	_____
Anxiety	___	___	_____
Fever, Sweating	___	___	_____

HEENT

Head Trauma	___	___	_____
Headaches	___	___	_____
Epistaxis	___	___	_____
Hoarseness	___	___	_____
Vision changes	___	___	_____

Cardiovascular

Change in exercise tolerance	___	___	_____
Shortness of breath	___	___	_____
Chest/pain/discomfort	___	___	_____
Palpitations	___	___	_____

Dizziness _____

Gastrointestinal

Ingestion or nausea (especially A.M.) _____

Heavy retching _____

Vomiting (with blood?) _____

Abdominal pain _____

Jaundice _____

Diarrhea _____

Black "tarry" stools _____

Genitourinary

Trouble getting an erection _____

Polyuria _____

Amenorrhea _____

Neuropsychiatric

Tremors (especially A.M.) _____

Blackouts _____

Memory problems/changes _____

Periods of confusion _____

Hallucinations _____

Staggering/balance problems _____

Paresthesias _____

Muscle weakness _____

Depressed? Down mood _____

Change in appetite _____

Decreased energy level _____

Decreased activity level _____

Suicide attempts/ideation _____

Sleep (hrs.) _____ EMA _____ MCA _____ TFA _____ Changes _____

V. Substance Use History

Alcohol

Do you use alcohol? _____

How often (days per week) do you drink? _____

What do you prefer? _____ How much do you drink per day? _____

How many drinks until you feel happy? _____ How many until you feel drunk? _____

Is this more than it has taken in the past? _____

Has there been any change in your pattern over the past 6 months or 1 year? _____

What age did you begin using alcohol? _____

Have you ever drunk (in one day): Case of beer? _____ Fifth of liquor _____ Gallon of wine? _____

Have you ever used non-beverage alcohol? _____

Longest period without alcohol? _____

Why did you stop? _____

Did you experience any discomfort? (hallucinations, tremors, fever) _____

Drugs

What drugs other than alcohol have you used? _____ How much _____

When did you last use these drugs? _____

When using, how much do you spend on drugs in a week? _____

Consequences of use

Has drinking or drug use ever caused you to miss or be late for work? _____

Has drinking or drug use ever affected your relationships or home life? _____

How do you feel about your drinking or drug use? _____

Has your physician ever told you to cut down or quit? _____

Have you ever attended an AA meeting? _____ Why? _____

CAGE Screening Test

C _____ Have you every felt the need to **C**ut down on your drinking?

A _____ Have you ever felt **A**nnoyed when other criticize your drinking?

G _____ Have you ever felt **G**uilty about your drinking?

E _____ Have you ever had a drink as an **E**ye opener to get going in the morning or to stop tremors?

When was your last drink? _____ How much? _____ What? _____

When was your last drug use? _____ What? _____ How much? _____

VI. Physical Examination

General

Appearance (dress, cleanliness, etc.)

Blood pressure _____ Respiratory rate ___ / minute

Pulse _____ Regular _____ Irregular ___ Explain _____

Behavior

	Yes	No	Explain
Anxious	___	___	_____
Irritable	___	___	_____
Uncooperative	___	___	_____
Hyperactive	___	___	_____
Alcohol on breathe	___	___	_____

Dermatology

Vascular dilation	___	___	_____
Clubbing/edema	___	___	_____
Deputyrens contractures	___	___	_____
Rhinophyma	___	___	_____
Palmer erythema	___	___	_____
Cigarette burns	___	___	_____
Spider nevi	___	___	_____

IV drug needle marks _____
Other burns/scars not attributable to surgery? Where _____

HEENT

Evidence of head trauma _____
Extraocular movements intact _____ Explain _____
Pupil Size _____ PERRIA _____ Sclera Clear _____ Icteric _____
Nasal septum: Intact _____
Periodontal Disease Yes _____ No _____
Swollen Parotids Yes _____ No _____

Chest

Gynecomastia _____
Lungs Clear to A&P _____ Dullness _____ Rales _____ Rhonchi _____ Wheezes _____
Heart — PMI: size and location _____
Rhythm Regular _____ Irregular _____ Explain _____
Sounds S1 _____ S2 _____ Others? (S3, S4, Rubs, Gallops) _____
Murmur (describe if possible) _____

Abdominal Examination

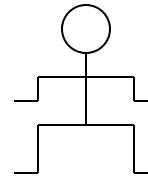
Bowel sounds (+ / -) _____
Ascites _____ Tenderness _____ Masses _____
Liver (size @MCL) _____ Palpable? _____ Splenomegaly _____

Neuropsychiatric

Cranial nerves intact? _____
Cerebellar: Tremor _____ Tandem Walk _____ F to N _____ Romberg + / - ? _____

Extremities

Sensory (upper + lower) intact _____
Symmetrical _____
Motor (upper + lower) intact _____
Symmetrical _____



Cognition

Object Retention 3 @ _____ minute
World _____
Serial Sevens _____

Assessment of Alcohol Use/Drug Use _____

Withdrawal Risk _____

Interviewer's Name _____ Date _____