New Hampshire Professionals Health Program

Sally Garhart MD
Medical Director

P.O. Box 6274
Amherst, NH 03031

Deanne Chapman, PA-C
Assistant Director

603-491-5036
Fax 603-924-0161

INITIAL INTERVIEW QUESTIONAIRE

NAME: _____ **DATE:**_____

ADDRESS: _____ **D.O.B.:**_____

HOW DID YOU HEAR ABOUT THE NH PHP? _____

( ) Physician ( ) Physician Assistant ( ) Veterinarian ( ) Dentist ( ) Pharmacist
DESCRIBE YOUR PRACTICE? _____

HOME PH: _____ **CELL PH:** _____ **WORK PH:** _____

Please circle the best number to reach you at during normal business hours

E-MAIL ADDRESS: _____
PRACTICE ADDRESS: _____

LIST THE NAMES AND PHONE NUMBERS OF THE FOLLOWING (if applicable):

Personal physician:_____ PH # _____
Psychiatrist:_____ PH#: _____
Therapist/counselor: _____ PH#: _____
Legal representative: _____ PH#: _____

MEDICAL HISTORY

List the medical conditions that have been diagnosed over your lifetime regardless of whether you are treating them now.

List all of your surgical procedures and hospitalizations with dates.

List your most recent tests and dates.

Check and detail if you have ever been evaluated for:

( ) Substance Abuse	( ) Learning Disabilities	( ) ADHD or ADD
( ) Ulcers	( ) GI Bleeding	( ) Sleep apnea
( ) Unexplained Weight Loss/Gain	( ) Inflammatory or Irritable Bowel Disease	
( ) Insomnia / Problems sleeping	( ) Trouble With Hearing	( ) Seizures
( ) Depression/Emotional Disorder/Anxiety	( ) Suicide attempts or thoughts	( ) Frequent Headaches
( ) Syncope	( ) Metabolic syndrome	( ) Tuberculosis, + PPD
( ) Chronic pain	( ) Back Pain or Sciatica	( ) Diabetes
( ) Chest Pain	( ) Head injury / loss of consciousness / Concussion	

Details of Health History:

_____
_____
_____
_____

Please list any prescribed, over-the-counter medications, and/or herbal products taken routinely:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Date and provider of recent medical visit(s)_____

Date of your last FULL physical? _____Provider:_____

What is your smoking status now and in the past? _____

WHAT TYPE of ALCOHOLIC BEVERAGES DO YOU DRINK? _____

Usual amount: _____ Circle: daily weekly monthly yearly
How old were you when you had your first drink?_____
How old were you when you first got intoxicated? _____
Have you ever been stopped and charged with a DUI? No / Yes Dates: _____
Have you ever: blacked out? Had DTs?

Do you often use larger amounts or for a longer time than originally intended? Yes/no

Have you had a persistent desire or unsuccessful efforts to cut down or control use? Yes/no

Do you spend a great deal of time to obtain, use or recover from your drug of choice? Yes/no

Do you have a strong desire or craving to use alcohol or your drug of choice? Yes/no

Has recurrent use resulted in a failure to fulfill major role obligations at work, school or home? Yes/no

Do you continue to use despite persistent/recurrent social or interpersonal problems from use? Yes/no

Have you given up or reduced important social, occupational or recreational activities because of use of drugs or alcohol? Yes/no

Have you continued to drink or use drugs in situations in which it is physically hazardous? Yes/no

Have you continued to drink or use drugs despite knowledge of persistent or recurrent physical or psychological problems likely caused by your use? Yes/no

Have you noticed the need for markedly increased amounts of alcohol / drugs to achieve your desired level of effect or intoxication? Yes/no

Have you noted a diminished effect with continued use of the same amount? Yes/no

Have you had any withdrawal affects or needed to use something else to relieve or avoid withdrawal? Yes/no

Describe any legal issues with drugs or alcohol: _____

_____

DESCRIBE any psychological assessments, interventions, diagnoses or treatments in your lifetime.

_____

_____

_____

_____

Have you ever been asked to attend anger management training / treatment? _____

List details of all practice complaints, performance reviews or reviews you are aware of:

_____

_____

_____

LIST AGE of FIRST USE, HX of USE and MOST RECENT USE?

Marijuana_____
Cocaine _____
Stimulants _____
Benzodiazepines_____
Sleeping aids _____
LSD _____
Inhalants _____
Opioids_____
Other _____

DO YOU HAVE ANY CHRONIC PAIN ISSUES? ( ) Yes ( ) No

If yes, explain how you treat your pain symptoms:

_____

_____

_____

_____

HOW MANY HOURS PER NIGHT DO SLEEP (ON AVERAGE):_____

DO YOU ENGAGE IN EXERCISE?

( ) Daily ( ) Weekly ( ) Monthly ( ) Rarely ( ) Never
What type of exercise: _____

IS YOUR LIFE OUT OF BALANCE IN ANY OF THESE AREAS:
( )Sex ( )Food ( )Sleep ( )Gambling ( )Spending ( )Work ( ) Exercise

DO YOU REGULARLY ATTEND ANY RELIGIOUS ACTIVITY? ( ) Yes ( ) No
If yes, describe:_____

WHAT DO YOU DO FOR FUN? When??

_____
_____

EDUCATION/LICENSURE

Where/when did you graduate from college?_____Major?_____

Where did you attend professional school and dates? _____

List your training locations with dates:

_____
_____

What is your current debt load from schooling? _____ Credit cards? _____

Other debts?

What was your occupation(s) prior to professional school?

_____

Are you board certified, if applicable? ( ) Yes ( ) No
List dates and pass/fail results of all tests:_____

List all states where you currently hold a professional license:

_____

List the facilities where you have privileges and type of privileges: _____

_____

List all malpractice claims with date and current status: _____

_____

Describe problems with your license(s), legal or insurance status:

_____
_____
_____

Are you currently working? _____

PRIMARY EMPLOYER:_____
( ) FULL TIME ( ) PART TIME ( ) PER DIEM
How many hours do you work each week?_____

SECONDARY EMPLOYER(S):_____
How many hours do you work each week or month?_____

LIST ANY COMMITTEE WORK, SUPERVISORY, or LEADERSHIP COMMITMENTS YOU HAVE:
_____
_____
_____

Are there retention or recruitment challenges in your practice or group?_____
_____

Do you take call? ( ) No ( ) Yes - describe your call schedule:
_____
_____

How many hours of continuing education have you had this year? _____
Location:_____

When and where was your last vacation?_____

How many days of vacation do you usually take each year? _____

How many days / weeks of vacation are you entitled to by your contract? _____

Is your work environment:
( ) happy ( ) tolerable ( ) stressed ( ) miserable ( ) other

explain:_____
_____
_____

SOCIAL LIFE

Current marital status: ( )single ( )married ( )divorced ( )separated ( )widowed

Describe details of prior marriages or involved relationships: _____
_____

Do you have children? ( ) Yes ( ) No Stepchildren? ( ) No ( ) Yes List gender(s) and age(s):
_____
_____

Is your marriage /relationship /home life:
( ) happy ( ) tolerable ( ) stressed ( ) miserable ( ) other

explain:

_____

_____

Does your work often interfere with your family or person interests? _____

Do you share responsibility for household expenses with a spouse, partner or significant other?

_____

What would improve your work? _____

REASON FOR TODAY'S VISIT

Please describe why you are here today:

_____

_____

_____

_____

_____

_____

_____

The mission of the New Hampshire Professionals Health Program is to help health care professionals to safely and effectively perform their sensitive jobs.

I have answered the above questions to the best of my knowledge and I understand that this questionnaire and initial interview is to determine if participation in the NHPHP or further evaluation is warranted. This form is held with the strictest confidence and will not be reproduced or shared with anyone. However, if we later learn that you deliberately falsified or misrepresented your information on this form regarding substance abuse or any significant information needed to determine your ability to safely practice there may be sufficient grounds for reporting to the NH Board of Medicine, NH Board of Veterinary Medicine, NH Board of Pharmacy or the Board of Dental Examiners. Please help us to help you.

_____ ***Date*** _____

Signature

NHPHP Impression:

NHPHP Recommendations: