

Confidential Patient Questionnaire

Name: _____ or/MR#: _____

Gender: Male: _____ Female: _____ Other: _____ Date: _____

Please complete the following questions. Your answers will be kept confidential and will be used by your healthcare provider for your treatment. This information will be helpful in your medical care. However, you have the right to decline to answer.

A drink is defined as a 12-ounce beer, a glass of wine, or a “shot” of liquor. A 40-ounce beer is equal to 3 drinks.

- | To be Answered by MEN ONLY: | Circle the appropriate answer: | |
|--|---------------------------------------|----|
| M1. Do you typically drink more than 2 drinks per day? | Yes | No |
| M2. On average, do you drink more than 14 drinks per week? | Yes | No |
| M3. Do you ever drink more than 5 drinks at any one time? | Yes | No |

To be Answered by WOMEN and MEN OVER 65:

- | | | |
|---|-----|----|
| W1 Do you typically drink more than 1 drink per day? | Yes | No |
| W2. On average, do you drink more than 7 drinks per week? | Yes | No |
| W3. Do you ever drink more than 4 drinks at any one time? | Yes | No |

To be answered by ALL:

- | | | | | | | | |
|--|--------|------------|-----------------------|------------------------|-------------------------------|-----------|---------|
| 1. Do you use any drugs other than tobacco or those prescribed by a physician? | Yes | No | | | | | |
| 2. Do you take more medication than you need or is prescribed? | Yes | No | | | | | |
| 3. Do you get pain medication from more than one physician? | Yes | No | | | | | |
| 4. If you use other drugs, please circle which ones: | | | | | | | |
| Cocaine/
Crack | Heroin | Pain Pills | Downers/
Sedatives | Ecstasy/ Club
Drugs | Amphetamines,
Speed, Crank | Marijuana | Others: |
| 5. Have you ever felt you should cut down on your drinking or drug use? | Yes | No | | | | | |
| 6. Have people ever annoyed you by criticizing your drinking or drug use? | Yes | No | | | | | |
| 7. Have you ever felt bad or guilty about your drinking or drug use? | Yes | No | | | | | |
| 8. Have you ever had a drink or used a drug first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? | Yes | No | | | | | |
| 9. Has a physician ever told you to cut down or quit use of alcohol or drugs? | Yes | No | | | | | |
| 10. Has your drinking or drug use caused family problems? | Yes | No | | | | | |
| 11. When drinking or using drugs have you ever had a memory loss or blackout? | Yes | No | | | | | |

To be answered by ALL:

Please circle the word that best describes your answer:

- | | | | | |
|---|-----|----------|-------|-------|
| 12. Do you feel that alcohol or drugs are a problem in your life? | Yes | Probably | Maybe | Never |
| 13. Are drugs or alcohol a problem for anyone in your family? | Yes | Probably | Maybe | Never |
| 14. Would you be interested in speaking with a counselor about your or a loved one’s alcohol or drug use? | Yes | Probably | Maybe | Never |