Richard R Hill MD PhD
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Pepper Pike, Ohio 44122
(216) 292 0610

NAME: _____

DOB: _____

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below. Which of the following drugs have you used in the past year? (Check all that apply)

- ☐ speed, crystal, ritalin, adderal
- ☐ marijuana, pot, kush, herb, weed
- ☐ inhalants (paint thinner, aerosol, glue)
- ☐ valium, Xanax (tranquilizers)
- ☐ cocaine, crack
- ☐ heroin, oxycodone, Vicodin, oxycontin, Percocet, methadone (narcotics)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other _____

	None	1 or More
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○
If you answered "1 or more", please answer the following questions by checking the box that best describes you.	STOP	NEXT

	YES	NO
1. Have you used drugs other than those required for medical reasons?	☐	☐
2. Do you use more than one drug at a time?	☐	☐
3. Are you unable to stop using drugs when you want to?	☐	☐
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐	☐
5. Do you ever feel bad or guilty about your drug use?	☐	☐
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
7. Have you neglected your family because of your use of drugs?	☐	☐
8. Have you engaged in illegal activities in order to obtain drugs?	☐	☐
9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	☐
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?)	☐	☐

Last Revised: 07/30/2015

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NAME: _____
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Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Alcohol screening questionnaire

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or More
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○
If you answered "1 or more", please answer the following questions by circling the box that best describes you	**STOP**	**NEXT**

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year