Richard R Hill MD PhD
29425 Chagrin Blvd, Suite 301
Pepper Pike, Ohio 44122
(216) 292-0610

Name:_____

DOB:

Substance Use Questionnaire

Substance use effects your health and may impact medications that we prescribe for you. Please help us provide you with the safest and most effective medical care by answering the questions below. We will discuss this at your initial appointment
Thank you!

Which of the following drugs have you used in the past year (check all that apply):

☐ Stimulants (ritalin/adderall/speed/meth)
☐ Marijuana, DAB, Kush, Herb, Weed, Pot
☐ Inhalants, (paint thinner, aerosols, glue)
☐ Hallucinogens (LSD, Mushrooms, peyote)
☐ others_____

☐ Cocaine, crack
☐ heroin, oxycodone, Vicodin, oxycontin, Percocet, methadone
☐ Valium/Xanax/Ativan/Ambien etc

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? ☐ None ☐ One or more times

If you answered "one or more times", please answer the following questions:

Have you used drugs other than those required for medical reasons? ❑ Yes ❑ No
Do you use more than one drug at a time? ❑ Yes ❑ No
Are you unable to quit using drugs when you want to? ❑ Yes ❑ No
Have you had "blackouts" or "flashbacks" as the results of drug use? ❑ Yes ❑ No
Do you ever feel bad or guilty about your drug use? ❑ Yes ❑ No
Has your spouse/partner/friends/parents ever complained about/expressed concern over your involvement with drugs? ❑ Yes ❑ No
Have you neglected your family because of drug use? ❑ Yes ❑ No
Have you engaged in illegal activities in order to obtain drugs? ❑ Yes ❑ No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking a particular drug? ❑ Yes ❑ No
Have you ever experienced medical problems as a result of your drug use ie: memory loss, liver problems, seizures, bleeding, stomach issues ❑ Yes ❑ No

Richard R Hill MD PhD
29425 Chagrin Blvd, Suite 301
Pepper Pike, Ohio 44122
(216) 292-0610

Name:_____

DOB:

Alcohol Use Questionnaire

Drinking alcohol can effect your health and may impact medications we may prescribe for you. Please help us provide you with the safest and most effective medical care by answering the questions below. We will discuss this at your initial appointment

One drink = 12 oz beer 🍺, or 5 oz wine 🍷, or 1.5 oz liquor (1 shot) 🍹

MEN: How many times in the past year have you had 5 or more drinks in one day?
❑ None ❑ 1 or more
WOMEN: How many times in the past year have you have 4 or more drinks in a day
❑ None ❑ 1 or more

If you answered "one or more times", please answer the following questions by circling the answer that best describes you:

1) How often do you have a drink containing alcohol?
Never, Monthly or less, 2-4 times/month, 2-3 times/week, >4 times/week

2) How many drinks containing alcohol do you have on a day when drinking?
0-2, 3-4, 5-6, 7-9, >10

3) How often do you have 4 or more drinks on one occasion?
Never, Less than monthly, Monthly, Weekly, Daily/almost daily

4) How often in the past year were you not able to stop drinking on e started?
Never, Less than monthly, Monthly, Weekly, Daily/almost daily

5) How often during the last year have you failed to do what was normally expected of you because of drinking alcohol? Never, Less than monthly, Monthly, Weekly, Daily/almost daily

6) How often during the last year have you needed a drink first thing in the AM to get going?
Never, Less than monthly, Monthly, Weekly, Daily/almost daily

7) How often during the last year have you felt guilty/remorseful after drinking?
Never, Less than monthly, Monthly, Weekly, Daily/almost daily

8) How often during the last year were you unable to remember what happened the night before because you had been drinking? Never, Less than monthly, Monthly, Weekly, Daily/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 friend, relative, doctor/clinician expressed concern about your drinking, suggested you cut down? No, Yes-but not in past year, Yes-in last year