

ALCOHOL

Do You Drink Alcohol? YES NO

If yes, please indicate the following

Hard Liquor YES NO
1 oz 2 oz 3 oz
Daily Weekly Monthly

Beer YES NO
1-2 Beverages 3-4 Beverages
5-6 Beverages 7 + Beverages
Daily Weekly Monthly

Wine YES NO
1-2 Beverages 3-4 Beverages
5-6 Beverages 7 + Beverages
Daily Weekly Monthly

Do You Drink Coffee? YES NO

Please indicate the following:

Caffeinated Decaffeinated

of Cups / Day _____

Do you use recreational drugs? YES NO

If yes, please indicate the following:

Marijuana? YES NO
If yes, how often? Daily Weekly Monthly

Cocaine? YES NO
If yes, how often? Daily Weekly Monthly

IV drugs? YES NO
If yes, how often? Daily Weekly Monthly

Other? YES NO
If yes, how often? Daily Weekly Monthly

Do you drink soda? YES NO

If yes, indicate:

Brand _____
How Much _____

Do you use Tobacco YES NO

If yes, please indicate the following:

Cigarettes Cigars Pipe Smokeless Tobacco

