

## ALCOHOL CONSUMPTION AND/OR DRUG USE QUESTIONNAIRE

First name and last name	Date of birth			Reference number: Case ID, Policy no., Contract no. or Application no.				
	Y	M	D					
1. Do you currently:    a) use drugs <input type="checkbox"/> Yes <input type="checkbox"/> No                      b) drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you ever:        a) used drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No                      b) drunk alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No								
<b>DRUG USE (using the table below, list the drugs that you have used in the past or are currently using)</b>								
Type	Yes	No	Dosage or quantity	Frequency of use	Duration (year)			
a) <b>OPIUM</b> (op), <b>HEROIN</b> , (stuff, junk, horse, H, smack), <b>MORPHINE</b> , <b>CODEINE</b> , <b>DEMEROL</b> , <b>METHADONE</b>	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
b) <b>BARBITURATES</b> (goof balls, downers, barbs, reds, yellow jackets, candy, etc.), Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
c) <b>AMPHETAMINES</b> (speed, uppers, pep pills, wake-ups, etc.), Benzedrine, Dexedrine, Methedrine	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
d) <b>MARIJUANA</b> (pot, grass, weed, joint, hashish, cannabis, hemp, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
e) <b>COCAINE</b> (crack), <b>METAMPHETAMINES</b> (cristal. chalk)	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
f) <b>HALLUCINOGENS</b> (mescaline, LSD (acid), DMT, peyote, psilocybin)	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
g) <b>ECSTASY</b>	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
h) <b>ANABOLIC STEROIDS</b>	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
i) <b>OTHERS</b> (specify)	<input type="checkbox"/>	<input type="checkbox"/>			From:    to:			
<b>ALCOHOL CONSUMPTION (complete the table below)</b>								
CURRENT CONSUMPTION				PAST CONSUMPTION IF DIFFERENT FROM CURRENT				
Quantity	Wine	Beer	Alcohol	Quantity	Wine	Beer	Alcohol	Duration (year)
Day				Day				From:    to:
Week				Week				From:    to:
Month				Month				From:    to:
3. Have you ever consulted a physician or been treated for: <b>drug abuse?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>alcohol abuse?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , indicate the name and address of the physician and the institute in question: _____ _____ Are you part of a support group such as N.A. or A.A.? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If <b>Yes</b> , since when? _____ (months/year)								
4. Have you ever been arrested for impaired driving? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , give details: _____ _____ date(s): _____								
5. When did you reduce your consumption of or stop using: drugs? _____ (month/year)                      alcohol? _____ (month/year)								
I declare that the answers given in this document are true and complete and I agree that they form an integral part of my application for insurance.								
Date			Signature of proposed insured <small>(signature of father, mother or legal guardian, if minor)</small>			Signature of witness		