AUDIT Questionnaire

Patient ID __ __ - __ __ __ __ - __ __ __

Date of Evaluation: ___ / ___ / _____

Protocol timepoint *(see codes)*: _____

Instructions: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one checkbox that best describes your answer to each question.

1. How often do you have a drink containing alcohol? 0 ☐ Never *Skip questions 2 through 8* 1 ☐ Monthly or less 2 ☐ 2 to 4 times a month 3 ☐ 2 to 3 times a week 4 ☐ 4 or more times a week	6. How often in the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? 0 ☐ Never 1 ☐ Less than monthly 2 ☐ Monthly 3 ☐ Weekly 4 ☐ Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? 0 ☐ 1 or 2 1 ☐ 3 or 4 2 ☐ 5 or 6 3 ☐ 7, 8, or 9 4 ☐ 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? 0 ☐ Never 1 ☐ Less than monthly 2 ☐ Monthly 3 ☐ Weekly 4 ☐ Daily or almost daily
3. How often do you have six or more drinks on one occasion? 0 ☐ Never *Skip questions 4 through 8 if the Total score for questions 2 & 3 = 0* 1 ☐ Less than monthly 2 ☐ Monthly 3 ☐ Weekly 4 ☐ 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? 0 ☐ Never 1 ☐ Less than monthly 2 ☐ Monthly 3 ☐ Weekly 4 ☐ 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? 0 ☐ Never 1 ☐ Less than monthly 2 ☐ Monthly 3 ☐ Weekly 4 ☐ Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? 0 ☐ No 2 ☐ Yes, but not in the last year 4 ☐ Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? 0 ☐ Never 1 ☐ Less than monthly 2 ☐ Monthly 3 ☐ Weekly 4 ☐ Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? 0 ☐ No 2 ☐ Yes, but not in the last year 4 ☐ Yes, during the last year

Total score ☐

Form completed by *(check all that apply)*:
☐ Patient ☐ Coordinator ☐ Interpreter
☐ Family member/friend ☐ Other