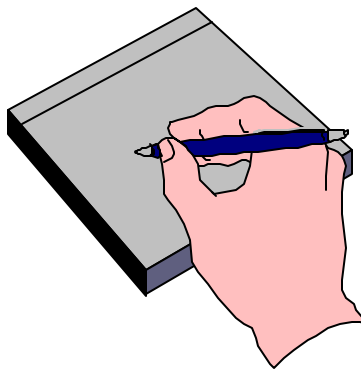


Office Use:
PID #
Pt. DOB
Patient's Name

ALCOHOL-RELATED PROBLEMS SURVEY

This survey is about the health of older people and their use of alcohol. Your information is valuable in helping us understand how to prevent disease and promote well-being.



This publication was made possible by a grant from the National Institutes of Health. The opinions expressed herein do not necessarily reflect the official position of the National Institutes of Health or any of its Institutes.

Now, please turn to page 1 of this survey.

SECTION 1: HEALTH PROBLEMS

This section is about your current health.

FILL IN (●) ONE CIRCLE ON EACH LINE

1. Has a <u>doctor or other health care worker</u> ever told you that you have:	NO	YES	DON'T KNOW
a. High blood pressure	0	0	0
b. Congestive heart failure	0	0	0
c. Diabetes	0	0	0
d. Osteoporosis	0	0	0
e. Cirrhosis or another liver condition	0	0	0
f. Cancer of the mouth or throat	0	0	0
g. Breast cancer	0	0	0
h. Gout	0	0	0
i. Memory disorder or dementing illness	0	0	0
j. Colorectal cancer	0	0	0

DID YOU FILL IN ONE CIRCLE ON EACH LINE,
EVEN IF YOUR ANSWER IS "DON'T KNOW"?

FILL (●) IN ONE CIRCLE ON EACH LINE

2. In the past twelve months, has a doctor or other health care worker told you that you have:

	NO	YES	DON'T KNOW
a. Hepatitis	0	0	0
b. Gastritis	0	0	0
c. Ulcer of the stomach or small intestine	0	0	0
d. Pancreatitis	0	0	0
e. Depression, anxiety or another emotional or mental health problem	0	0	0

3. Do you now use tobacco in any form, including cigarettes, cigars, pipes, chewing tobacco, etc.?

FILL IN (●) ONE CIRCLE

<input type="radio"/>	No, I have <u>never</u> used tobacco.
<input type="radio"/>	No, I used tobacco <u>in the past</u> , but I do not use it now.
<input type="radio"/>	Yes, I use tobacco <u>now</u> .

4. How much of the time during the past 12 months did you have any of the following problems?

FILL IN (●) ONE CIRCLE ON EACH LINE

	<u>None</u> of the time	<u>A Little</u> of the time	<u>Some</u> of the time	<u>Most</u> Of the time	<u>All</u> of the time
a. Problems sleeping	0	0	0	0	0
b. Stomach pains	0	0	0	0	0
c. Heartburn	0	0	0	0	0
d. Nausea	0	0	0	0	0
e. Vomiting	0	0	0	0	0
f. Diarrhea	0	0	0	0	0
g. Nervousness	0	0	0	0	0
h. Memory problems	0	0	0	0	0
i. Feeling depressed	0	0	0	0	0
j. Tripping, bumping into things	0	0	0	0	0
k. Falling	0	0	0	0	0
l. Problems with bladder control	0	0	0	0	0

**DID YOU FILL IN ONE CIRCLE ON EACH LINE,
EVEN IF YOUR ANSWER IS “NONE OF THE TIME”?**

SECTION 2: MEDICATIONS

This section is about some medications you may be using.

5. How many different medications do you use EVERY DAILY OR ALMOST EVERY DAY. Count ALL, even if you get them without a doctor's prescription. (Do not count eye drops, vitamins, minerals, ointments.)

FILL IN (●) ONE CIRCLE

None

One to two

Three to five

Six to seven

Eight or more

6. Do you now take 2 or more regular or extra strength (325 mg or more) aspirins EVERY DAY or ALMOST EVERY DAY?

FILL IN (●) ONE CIRCLE

No

Yes

Don't know

FILL IN (●) ONE CIRCLE ON EACH LINE

7. Do you now take any of these medications at least ONCE A WEEK?	NO	YES	DON'T KNOW
a. Sedatives or sleeping medicines such as Ambien, Sonata, Restoril (temazapam), Valium, Dalmane, Librium, Xanax, Ativan, Halcion	0	0	0
b. Tranquilizers or anti-anxiety medicines such as Olanzapine, Zyprexa, Risperdal, Thorazine, Mellaril, Haldol	0	0	0
c. Narcotic medicines such as Darvon, Demerol, codeine, morphine, Percocet, Vicodin, Oxycodone, Oxycontin, Tramadol, Tylenol #3	0	0	0
d. Muscle relaxants such as Flexeril, Soma	0	0	0
e. Erectile dysfunction medicines such as Viagra, Cialis, Levitra	0	0	0

DID YOU FILL IN ONE CIRCLE ON EACH LINE, EVEN IF YOUR ANSWER IS "DON'T KNOW"?

FILL IN (●) ONE CIRCLE ON EACH LINE

8. Do you now take any of these medications EVERY DAY or ALMOST EVERY DAY?	NO	YES	DON'T KNOW
a. Ulcer and stomach medicines such as Zantac, Tagamet, Prilosec, Pepcid	0	0	0
b. Arthritis and pain medicines such as Celebrex, Motrin (Ibuprofen), Voltaren, Relafen, Lodine, Clinoril, Aleve (naprosyn), Tylenol, Advil, Bextra	0	0	0
c. Diabetes medicines such as Glyburide, Glipizide, metformin, Glucophage, Avandia, Actos	0	0	0
d. Blood pressure medicines such as Cardizem, Vasotec, Lotensin, Atenolol, Cozaar, Norvasc, water pills, Hyzaar, Lopressor, Captopril, Zestril. Alstace, Atacan	0	0	0
e. Nitrates such as Isordil, Nitropatch, Imdur	0	0	0
f. Other medicines for the heart such as digoxin, Lasix, Aldactone (spironlactone)	0	0	0
g. Coumadin (warfarin)	0	0	0

How about these medications? Do you now take any of these medications EVERY DAY or ALMOST EVERY DAY?

FILL IN (●) ONE CIRCLE ON EACH LINE

h. Seizure medicines such as Tegretol, Dilantin, Phenobarbital, Depakote, Keppra, Lamictal	0	0	0
i. Depression medicines such as Elavil (amitriptyline), Pamelor (nortriptyline), Paxil, Prozac, Zoloft, Celexa, Lexapro	0	0	0
j. Non- sedating, non drowsy- antihistamines such as Claritin, Zyrtec, Allegra	0	0	0
k. Sedating, sleep inducing antihistamines such as Tylenol PM, Benadryl, Chlortrimeton	0	0	0
l. Cholesterol lowering medicine like Lipitor, Zocor, Pravachol, Crestor	0	0	0
m. Medicines for the bladder such as Terazosin, Flomax, Hytrin	0	0	0

DID YOU FILL IN ONE CIRCLE ON EACH LINE, EVEN IF YOUR ANSWER IS “DON’T KNOW”?

SECTION 3: RECENT ALCOHOL USE

This section is about alcohol use during the past 12 months.

The next questions ask you to count drinks. When you answer, please count one drink of alcohol as equal to one of the following:



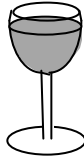
One 12-ounce can of beer

or



One 12-ounce bottle of wine cooler

or



One 5-ounce glass of wine

or



One 1.5-ounce shot of hard liquor such as whisky or scotch

or



One cocktail containing one shot (1.5 ounces) of hard liquor

9. During the past 12 months, how often did you have a drink containing alcohol?

FILL IN (●) ONE CIRCLE

Daily or almost daily

Four or five times a week

Two or three times a week

Two to four times a month

One time a month or less

Never ⇒ **Please go to page XXX.**

10. On days that you drank alcohol during the past 12 months, how many drinks of alcohol (*beer, wine, and/or hard liquor*) did you usually drink?

FILL IN (●) ONE CIRCLE

<input type="radio"/>	Five or more
<input type="radio"/>	Four
<input type="radio"/>	Three
<input type="radio"/>	Two
<input type="radio"/>	One
<input type="radio"/>	Less than one

11. During the past 12 months, how often did you have three or more drinks of alcohol at one sitting?

FILL IN (●) ONE CIRCLE

<input type="radio"/>	Daily or almost daily
<input type="radio"/>	Four or five times a week
<input type="radio"/>	Two or three times a week
<input type="radio"/>	Two to four times a month
<input type="radio"/>	One time a month or less
<input type="radio"/>	Never

12. During the past 12 months, how often did you have four or more drinks of alcohol at one sitting?

FILL IN (●) ONE CIRCLE

-
-
- Daily or almost daily
-
- Four or five times a week
-
- Two or three times a week
-
- Two to four times a month
-
- One time a month or less
-
- Never
-

13. Because of your alcohol use, how often in the past 12 months did you fail to do what you were supposed to do?

FILL IN (●) ONE CIRCLE

-
-
- Daily or almost daily
-
- At least once a week, but less than daily
-
- At least once a month, but less than weekly
-
- Less than once a month
-
- Never
-

14. Because of your alcohol use, how often in the past 12 months were you unable to stop drinking once you started?

FILL IN (●) ONE CIRCLE

-
-
- Daily or almost daily
-
- At least once a week, but less than daily
-
- At least once a month, but less than weekly
-
- At least once a month, but less than weekly
-
- Less than once a month
-
- Never
-

15. Because of your alcohol use, how often in the past 12 months did you feel guilty or sorry for something you did?

FILL IN (●) ONE CIRCLE

-
-
- Daily or almost daily
-
- At least once a week, but less than daily
-
- At least once a month, but less than weekly
-
- At least once a month, but less than weekly
-
- Less than once a month
-
- Never
-

16. In the past 12 months, on how many days did you drive a car, truck, or other vehicle within 2 hours of having three or more drinks?

FILL IN(●) ONE CIRCLE

<input type="radio"/>	20 or more days
<input type="radio"/>	10 –19 days
<input type="radio"/>	6 - 9 days
<input type="radio"/>	3 - 5 days
<input type="radio"/>	1 - 2 days
<input type="radio"/>	Never
<input type="radio"/>	I did not drive in the past 12 months

17. Has a doctor, other medical person, relative, friend, or anyone else ever been concerned about your drinking or suggested that you should cut down?

FILL IN (●) ONE CIRCLE

<input type="radio"/>	No
<input type="radio"/>	Yes, but <u>not</u> during the <u>past 12 months</u>
<input type="radio"/>	Yes, during the <u>past 12 months</u>

SECTION 4: The following question is about you in general.

18. The following are *physical* activities you might do during a typical day. How much are you limited in these activities because of your health?

FILL IN (●) ONE CIRCLE ON EACH LINE

	<u>Not limited</u> <u>at all</u> <i>because</i> <i>Of health</i>	<u>Limited</u> <u>a little</u> <i>because of</i> <i>health</i>	<u>Limited a lot</u> <i>because</i> <i>of health</i>
a. Climbing one flight of stairs	0	0	0
b. Walking one block	0	0	0
c. Bathing or dressing yourself	0	0	0

19. How would you describe your current health status?

- Excellent
- Very good
- Good
- Fair
- Poor

20. Are you male or female?

- Male
- Female