Alcohol Screening Questionnaire (AUDIT) ID: _____

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One Drink Equals:

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7-9	10 or more
3. How often do you have four or more drinks on occasion?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or 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 relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been treated for an alcohol problem? ❒ Never ❒ Currently ❒ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

Patient Name _____ DOB _____ Today's Date _____