Demographics (with PHI)

Record ID

_____

First Name

_____

Middle Name

_____

Last Name

_____

Age

_____
(Do not enter for patients >89 years old)

Date of Birth

_____

Sex assigned at birth

◯ Male
◯ Female
◯ Intersex/Other

Gender

◯ Man
◯ Woman
◯ Transgender man or transmasculine
◯ Transgender woman or transfeminine
◯ Nonbinary/gender fluid
◯ Other (describe below)

Describe:

_____

Ethnicity

◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Unknown
◯ Refused to answer

Race (select one or more)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown
☐ Other
☐ Refused

Place of birth (as listed on birth certificate)

_____

Contact information (email, phone number, best time to contact, etc.)

_____

MRN: _____

Medical History Prescreen

Record ID	_____
Pre-Screening Date	_____ (Initial Data Form Completion Date)

Medical History - Denver CARES (AUD) or Telephone (Control) Venues

Do you have a history of heart disease (coronary artery disease)?	◯ No ◯ Yes
Do you have a history of COPD or Emphysema?	◯ No ◯ Yes
Do you have a history of pulmonary fibrosis or pulmonary hypertension?	◯ No ◯ Yes
Do you have a history of diabetes?	◯ No ◯ Yes
Do you have a history of kidney problems?	◯ No ◯ Yes
Do you have a history of cirrhosis of the liver, ascites, or variceal bleeding?	◯ No ◯ Yes
Do you have a history of hepatitis B or C?	◯ No ◯ Yes
Do you have a history of HIV positivity?	◯ No ◯ Yes
Do you have a history of hypertension (high blood pressure)?	◯ No ◯ Yes
Have you ever had asthma?	◯ No ◯ Yes
Do you STILL have asthma?	◯ No ◯ Yes
Have you had an attack of asthma at any time in the last 12 months?	◯ No ◯ Yes
Are you currently taking any medications for asthma? (including inhalers, aerosols, or tablets)	◯ No ◯ Yes
Any serious operations?	◯ No ◯ Yes

If yes, please explain

_____

Any head trauma or closed head injury?

◯ No
◯ Yes

If yes, please explain

_____

Have you ever been admitted to the hospital for GI bleeding?

◯ No
◯ Yes

If yes, please explain

_____

Have you ever been on a breathing machine?

◯ No
◯ Yes

When was the last time you were in the hospital and why?

_____

Have you used cocaine, heroin, or methamphetamine (any amount) in the past year?

◯ No
◯ Yes

Have you used cocaine, heroin, or methamphetamine (any amount) in the past 2 months?

◯ No
◯ Yes

Have you ever used any of these substances regularly?

◯ No
◯ Yes

What types of medications are you taking?

☐ None
☐ blood thinners or aspirin
☐ blood pressure medications
☐ seizure medications
☐ antibiotics
☐ inhalers
☐ HIV meds
☐ psychiatric meds
☐ birth control
☐ don't know
☐ other category

Other category: please specify type of medication

_____

Have you used antibiotics in the last month?

◯ No
◯ Yes

When was your most recent dose of antibiotics?

_____

Do you have any allergies to medications?

◯ No
◯ Yes

Please specify drug name:	_____
Type of allergic reaction	◯ Anaphylaxis ◯ Hives/Rash ◯ Nausea/Vomiting/Diarrhea ◯ Other
Please specify reaction	_____
Are you allergic to any additional medications?	◯ No ◯ Yes
Please specify drug name:	_____
Type of allergic reaction	◯ Anaphylaxis ◯ Hives/Rash ◯ Nausea/Vomiting/Diarrhea ◯ Other
Please specify reaction	_____
Are you allergic to any additional medications?	◯ No ◯ Yes
Please specify drug name:	_____
Type of allergic reaction	◯ Anaphylaxis ◯ Hives/Rash ◯ Nausea/Vomiting/Diarrhea ◯ Other
Please specify reaction	_____

Smoking History Prescreen

Record ID _____

Smoking History

Do you presently smoke cigarettes?
◯ No
◯ Yes

How many packs per day do you smoke? _____

How many years have you smoked for? _____

Have you ever smoked cigarettes?
◯ No
◯ Yes

How many packs did you smoke per day? _____
(1 pack = 20 cigarettes)

How many years did you smoke for? _____

How many years ago did you stop smoking? _____

Do you presently vape or use any other nicotine containing products?
◯ No
◯ Yes

How many years have you vaped or consumed other nicotine containing products? _____

Have you ever vaped or used any other nicotine containing products?
◯ No
◯ Yes

How many years did you vape or consume other nicotine containing products? _____

Alcohol History Prescreen

Record ID _____

Alcohol Questions

Have you consumed alcohol in the past 7 days?
◯ No
◯ Yes

Date of last drink _____

Age first started drinking alcohol _____

Denver CARES Patient?
◯ No
◯ Yes

Do you ever have alcohol withdrawal?
◯ No
◯ Yes

Please describe your typical alcohol withdrawal symptoms _____

Have you ever needed Tranxene for alcohol withdrawal?
◯ No
◯ Yes

How long ago was the last time you received Tranxene? _____
(Enter in number of days, weeks, or months (e.g. 3 days ago) - do not enter exact date)

AUDIT Prescreen

Record ID	_____
1. How often do you have a drink containing alcohol?	◯ Never (0) ◯ Monthly or less (1) ◯ 2 to 4 times a month (2) ◯ 2 to 3 times a week (3) ◯ 4 or more times a week (4)
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	◯ 1 or 2 drinks (0) ◯ 3 or 4 drinks (1) ◯ 5 or 6 drinks (2) ◯ 7 to 9 drinks (3) ◯ 10 or more drinks (4)
3. How often do you have 6 or more drinks on one occasion?	◯ Never (0) ◯ Less than monthly (1) ◯ Monthly (2) ◯ Weekly (3) ◯ Daily or almost daily (4)
How often during the last year have you been unable to remember what happened the night before because of your drinking?	◯ Never (0) ◯ Less than monthly (1) ◯ Monthly (2) ◯ Weekly (3) ◯ 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 (0) ◯ Less than monthly (1) ◯ Monthly (2) ◯ Weekly (3) ◯ Daily or almost daily (4)
Have you or someone else been injured because of your drinking?	◯ No (0) ◯ Yes, but not in the last year (2) ◯ Yes, during the last year (4)
How often during the last year have you failed to do what was normally expected of you because of drinking?	◯ Never (0) ◯ Less than monthly (1) ◯ Monthly (2) ◯ Weekly (3) ◯ Daily or almost daily (4)
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	◯ No (0) ◯ Yes, but not in the last year (2) ◯ Yes, during the last year (4)
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 (0) ◯ Less than monthly (1) ◯ Monthly (2) ◯ Weekly (3) ◯ Daily or almost daily (4)

How often during the last year have you had a feeling of guilt or remorse after drinking?	◯ Never (0) ◯ Less than monthly (1) ◯ Monthly (2) ◯ Weekly (3) ◯ Daily or almost daily (4)
AUDIT-C Score	_____
AUDIT score	_____

Marijuana Use Prescreen

Record ID	_____
For how many years have you been using marijuana that is inhaled?	_____
How many times in the last week have you used inhaled marijuana?	_____
How often do you smoke marijuana (number of bowls/ joints per day)?	_____
Do you vape marijuana? If so how often?	_____
Do you dab marijuana? If so, how often?	_____
Do you smoke blunts? If so, how often?	_____
Do you use edibles? If so, how often?	_____