Medical History Prescreen

Please complete the survey below.

Thank you!

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
What types of medications are you taking?	☐ None ☐ blood thinners or aspirin ☐ blood pressure medications ☐ seizure medications ☐ antibiotics ☐ inhalers ☐ HIV meds ☐ psychiatric meds ☐ don't know ☐ other category
Other category: please specify type of medication	_____
Antibiotics: Date of first dose	_____
Antibiotics: Date of last dose	_____
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	_____

MJ usage prescreen

Please complete the survey below.

Thank you!

1) For how many years have you been using marijuana that is inhaled? _____

2) How many times in the last week have you used inhaled marijuana? _____

3) How often do you smoke marijuana (number of bowls/ joints per day)? _____

4) Do you vape marijuana? If so how often? _____

5) Do you dab marijuana? If so, how often? _____

6) Do you smoke blunts? If so, how often? _____

7) Do you use edible? If so, how often? _____

Smoking History Prescreen

Please complete the survey below.

Thank you!

Smoking History

Do you presently smoke or vape cigarettes or nicotine containing products?	◯ No ◯ Yes
How many packs per day do you smoke?	_____
How many years have you smoked for?	_____
Have you ever smoked or vaped cigarettes or nicotine containing products?	◯ 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?	_____

Alcohol History Prescreen

Please complete the survey below.

Thank you!

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
Breathalyzer	_____
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)
When do you need Tranxene?	_____

Audit Prescreen

Please complete the survey below.

Thank you!

	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)
1. How often do you have a drink containing alcohol?	○	○	○	○	○

	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)
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	○	○	○	○	○

	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)
3. How often do you have 6 or more drinks on one occasion?	○	○	○	○	○
4. How often during the last year have you found that you were not able to stop drinking once you had started?	○	○	○	○	○
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	○	○	○	○	○
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?	○	○	○	○	○
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	○	○	○	○	○
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	○	○	○	○	○

	No (0)	Yes, but not in the last year (2)	Yes, during the last year (4)
9. Have you or someone else been injured because of your drinking?	○	○	○

10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	○	○	○

AUDIT score _____