**CONTACT/DEMOGRAPHIC INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For WOMEN ONLY:

Are you pregnant? YES / NO

Age: \_\_\_\_\_\_\_\_\_\_\_ Gender: MALE / FEMALE 🡪🡪🡪🡪

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (home / cell)

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our study? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOBACCO USE**

“Have you ever smoked cigarettes?” YES / NO

If YES, “Do you currently smoke cigarettes?”; If NO, proceed to other substance use section

|  |  |  |  |
| --- | --- | --- | --- |
| **CURRENT SMOKER QUESTIONS** | | **FORMER SMOKER QUESTIONS** | |
| “How often do you smoke?”  (“Daily, most days, some days?”) |  | “When was the last time you smoked?” |  |
| “On days when you smoke, how many cigarettes do you smoke usually?” |  | “How many cigarettes have you ever smoked?” |  |

**OTHER SUBSTANCE USE**

“Have you ever used marijuana?” YES / NO

If YES, “When was the last time you used marijuana?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used marijuana?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Have you ever used cocaine?” YES / NO

If YES, “When was the last time you used cocaine?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used cocaine?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Have you ever used ecstasy?” YES / NO

If YES, “When was the last time you used ecstasy?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used ecstasy?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Have you ever used methamphetamine?” YES / NO

If YES, “When was the last time you used methamphetamine?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used methamphetamine?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Have you ever used heroin?” YES / NO

If YES, “When was the last time you used heroin?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used heroin?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**“For the next questions, we are asking about your use of prescription medications. Specifically, we want to know if you ever used a prescription medication that was not prescribed for you or whether you ever used a prescription medication for the feeling it caused”**

(For each, include “that was not prescribed for you or for the feeling it caused”)

“Have you ever used a prescription opiate, like OxyContin, Vicodin or Darvocet?” YES / NO

If YES, “When was the last time you used one of these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For each, include “that was not prescribed for you or for the feeling it caused”)

“Have you ever used a prescription tranquilizer, like Xanax or Ativan?” YES / NO

If YES, “When was the last time you used one of these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For each, include “that was not prescribed for you or for the feeling it caused”)

“Have you ever used a prescription stimulant, like Ritalin, Adderall or Concerta?” YES / NO

If YES, “When was the last time you used one of these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For each, include “that was not prescribed for you or for the feeling it caused”)

“Have you ever used a prescription sedative, like Tuinal, Seconal or Ambien?” YES / NO

If YES, “When was the last time you used one of these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “How many times have you ever used these medications?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any prescription medications or YES / NO

over the counter medications?

If YES, “How long have you been taking it for?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also if YES, “What condition are you taking this for?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER CRITERIA**

“Do you have any (other) medical conditions that we should be aware of?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[SPECIFICALLY QUERY FOR SKIN ALLERGIES OR PROBLEMS]** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Have you ever seen a psychologist, psychiatrist or other mental health professional?” YES / NO

If YES, “Can you tell me what that was for?” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_