

SUBSTANCE ABUSE MODULE (SAM[©])

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ID CODE: ____/____/____/____/____/____

INTERVIEWER: ____/____/____

DATE: ____/____/____/____/____/____
MONTH DAY YEAR**SECTION A**

A1. RECORD SEX AS OBSERVED. MALE 1
FEMALE 5

Let's start with some basic questions we ask everyone.

A2. Where were you born?

CITY STATE COUNTRY

A3. In what year were you born? YEAR ____/____/____/____

A4. On what date? ____/____/____
MONTH DAY

A5. So you're how old now? AGE ____/____

A6. HAND CARD 1 TO R. Which of these racial or ethnic groups best describes you?

| | | | |
|--------------------------------|----|--------------------------|----|
| ALASKAN NATIVE/ESKIMO/ALEUT .. | 10 | LATINO OR HISPANIC, NON- | |
| AMERICAN INDIAN | 20 | BLACK: | |
| ASIAN OR ASIAN-AMERICAN: | | Cuban | 50 |
| Chinese | 30 | Dominican | 51 |
| (East) Indian | 31 | Mexican | 52 |
| Filipino | 32 | Puerto Rican | 53 |
| Japanese | 33 | Other | 54 |
| Other | 34 | MIDDLE EASTERN. | 60 |
| BLACK: | | PACIFIC ISLANDER. | 70 |
| African American | 40 | WHITE, CAUCASIAN, EURO- | |
| Caribbean or West Indian | 41 | AMERICAN, NOT OF LATINO | |
| Latino: | | ORIGIN | 80 |
| Cuban | 42 | BIRACIAL OR MULTIRACIAL | |
| Dominican | 43 | (SPECIFY) _____ | 90 |
| Puerto Rican | 44 | OTHER (SPECIFY) _____ | 96 |
| Other | 45 | | |

A7. What language do you usually speak at home?

| | |
|----------------|-----|
| ENGLISH | 1 |
| SPANISH | 2 |
| MANDARIN | 3 |
| HINDI | 4 |
| FRENCH | 5 |
| ARABIC | 6 |
| GERMAN | 7 |
| TURKISH | 8 |
| OTHER: _____ | . 9 |

(SPECIFY)

A8. Before you were 15, was there a time when you did not live with your biological mother for at least 6 months?
R SHOULD NOT INCLUDE TIME AWAY AT SCHOOL.

| | |
|-----------------------|---|
| NO .. GO TO A10 | 1 |
| YES | 5 |

A9. At what ages were you living apart from your biological mother?
CIRCLE ALL THAT APPLY.

00 01 02 03 04 05 06 07 08 09 10 11 12 13 14

INFANT

A10. Before you were 15, was there a time when you did not live with your biological father for at least 6 months?
R SHOULD NOT INCLUDE TIME AWAY AT SCHOOL.

| | |
|-----------------------|---|
| NO .. GO TO A12 | 1 |
| YES | 5 |

A11. At what ages were you living apart from your biological father?
CIRCLE ALL THAT APPLY.

00 01 02 03 04 05 06 07 08 09 10 11 12 13 14

INFANT

A12. What is your current marital status -- married, widowed, separated, divorced, or never married?

| | |
|-----------------------|---|
| MARRIED | 1 |
| WIDOWED | 2 |
| SEPARATED | 3 |
| DIVORCED | 4 |
| NEVER MARRIED | 5 |
| GO TO A16 | 5 |

A13. How many times have you been married? # TIMES ___/___

A14. How old were you (when/the first time) you got married? ___/___
AGE

- A. IF A13 (TIMES MARRIED) = 1, CODE RESPONSE FROM A12 (CURRENT STATUS) BELOW WITHOUT ASKING THE QUESTION.

Did that marriage end in your being widowed or divorced?

MARRIED. . GO TO A16 1
WIDOWED 2
SEPARATED 3
DIVORCED 4

- B. How old were you when you (were/got) (STATUS IN A14A) (that time)?

 /
AGE

- A15. IF A13 (TIMES MARRIED) = 1, GO TO A16.
How old were you the second time you got married?

 /
AGE

- A. IF A13 (TIMES MARRIED) = 2, CODE RESPONSE FROM A12 (CURRENT STATUS) BELOW WITHOUT ASKING THE QUESTION.

Did that marriage end in your being widowed or divorced?

MARRIED. . GO TO A16 1
WIDOWED 2
SEPARATED 3
DIVORCED 4

- B. How old were you when you (were/got) (STATUS IN A15A) (that time)?

 /
AGE

- C. IF A13 (TIMES MARRIED) = 1 OR 2, GO TO A16.
How old were you the third time you got married?

 /
AGE

- D. IF A13 (TIMES MARRIED) = 3, CODE RESPONSE FROM A12 (CURRENT STATUS) BELOW WITHOUT ASKING THE QUESTION.

Did that marriage end in your being widowed or divorced?

MARRIED. . GO TO A16 1
WIDOWED 2
SEPARATED 3
DIVORCED 4

- E. How old were you when you (were/got) (STATUS IN A15D) (that time)?

 /
AGE

F. IF A13 (TIMES MARRIED) = 1, 2, OR 3,
GO TO A16.

How old were you the fourth time you got
married?

____/____
AGE

G. IF A13 (TIMES MARRIED) = 4, CODE
RESPONSE FROM A12 (CURRENT
STATUS) BELOW WITHOUT ASKING
THE QUESTION.

Did that marriage end in your being
widowed or divorced?

MARRIED. . GO TO A16 1
WIDOWED 2
SEPARATED 3
DIVORCED 4

H. How old were you when you (were/got)
(STATUS IN A15G) (that time)?

____/____
AGE

A16. Have you ever lived with someone as though you
were married?

NO .. GO TO A17 1
YES 5

A. What is the longest time you lived with
someone as though you were married?

____/____/____
MONTHS

ONS: How old were you when you began to live
with that person?

____/____
AGE

A17. How many children have you (FEMALE: given
birth to?/MALE: fathered? Do not include adopted,
foster, or step children.)

CHILDREN ____/____

A18. How many years of schooling have you completed?
IF 00, CODE A18A=1 AND GO TO A19.

YEARS ____/____

A. What is the highest education degree or certificate you hold?

NONE 1
ELEMENTARY OR JUNIOR HIGH 2
GED 3
HIGH SCHOOL DIPLOMA 4
VOCATIONAL TECH DIPLOMA 5
ASSOCIATE DEGREE 6
R.N. DIPLOMA 7
BACHELOR DEGREE 8
MASTER DEGREE 9
DOCTORATE: M.D., Ph.D., J.D., etc. 10

A19. In the past 12 months, how many months did you work for pay full time? FULL TIME /
MONTHS
FULL TIME = 35 HOURS OR MORE PER WEEK. IF 12 MONTHS, GO TO A20.

A. During the past 12 months when you were not working full time, how many months did you work part-time? PART TIME /
MONTHS

A20. Now I'm going to ask you some questions about your health. During the past 12 months, would you say that your health in general has been excellent, good, fair, or poor?
EXCELLENT 1
GOOD 2
FAIR 3
POOR 4

| A21. Have you ever been under a doctor's care for -- (READ ILLNESSES AND CODE IN COL. I) | COL. I | | COL. II |
|---|-----------|------------|---------------------------|
| | <u>NO</u> | <u>YES</u> | <u>ONSET AGE</u> |
| 1. Heart attack? | 1 | 5 | <u> </u> / <u> </u> |
| 2. Cancer? Type: _____ | 1 | 5 | <u> </u> / <u> </u> |
| 3. Stroke? | 1 | 5 | <u> </u> / <u> </u> |
| 4. Diabetes? | 1 | 5 | <u> </u> / <u> </u> |
| 5. Tuberculosis? | 1 | 5 | <u> </u> / <u> </u> |
| 6. Any other serious physical illness? _____ | 1 | 5 | <u> </u> / <u> </u> |
| (SPECIFY) | | | |

IF NONE CODED 5, GO TO B1.

A. How old were you when you first found out you had (ILLNESS CODED 5)? CODE IN COL. II.

SECTION B

Now I'd like to ask you some questions about using tobacco.

| | | |
|--------------------|---|---|
| | B1. Have you smoked at least 20 cigarettes in your life? | NO ... GO TO B3 1 YES 5 |
| DSMTOBA DSMTOBW | A. Have you smoked any cigarettes in the past 12 months? | NO ... GO TO D 1 YES 5 |
| DSMTOBA DSMTOBW | B. How would you describe your usual pattern of cigarette smoking in the past 12 months? Would you describe it as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO D .. 6 |
| DSMTOBW | C. In the past 12 months, when you were smoking cigarettes (FREQUENCY IN B), how many would you usually smoke in a day? IF MORE THAN 95, CODE 96. | # CIGARETTES ____/____ |
| | D. When was the last time you had a cigarette? | TODAY 1 YESTERDAY 2 2 TO 6 DAYS AGO 3 7 TO 13 DAYS AGO 4 14 TO 20 DAYS AGO 5 21 TO 30 DAYS AGO 6 MORE THAN A MONTH AGO. .CODE REC BELOW .. 7 |
| | | ____/____ ____/____ MONTH AGE |

JAN = 01, FEB = 02, MAR = 03, APR = 04, MAY = 05, JUN = 06, JUL = 07, AUG = 08, SEP = 09, OCT = 10, NOV = 11, DEC = 12.

Refused = 97, Don't Know = 98

| | | | |
|--------------------|-----|---|--|
| DSMTOBA DSMTOBW | B2. | IF B1A CODED NO, GO TO A. Has there been a time in your life when you smoked more cigarettes than you did in the past 12 months? | NO GO TO E 1 YES 5 |
| DSMTOBA DSMTOBW | A. | In your period of heaviest smoking, would you describe your pattern of smoking as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO F ... 6 |
| DSMTOBW | B. | During that time when you were smoking cigarettes (FREQUENCY IN A), how many would you usually smoke in a day? IF MORE THAN 95, CODE 96. | # CIGARETTES ____/____ |
| | C. | How old were you when you started smoking (AMOUNT IN B) cigarettes (FREQUENCY IN A)? | AGE ____/____ |
| | D. | What is the longest period you smoked (AMOUNT IN B) cigarettes (FREQUENCY IN A)? ENTER DURATION AND CIRCLE UNIT. | ____/____ DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 |
| | E. | IF B1B=6 AND B2=NO, GO TO F. During your period of heaviest smoking, how soon after waking up did you have your first cigarette? Was it usually within the first ... | 5 minutes? 1 30 minutes? 2 Hour? 3 Later than that? 4 |
| | F. | How old were you the first time you smoked a cigarette? | AGE ____/____ |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS,
CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION B

| | | | |
|--------------------|-----|--|--|
| | B3. | Have you smoked more than 5 cigars in your life? | NO ... GO TO B5 1 YES 5 |
| DSMTOBA DSMTOBW | A. | Have you smoked any cigars in the past 12 months? | NO ... GO TO D 1 YES 5 |
| DSMTOBA DSMTOBW | B. | How would you describe your usual pattern of cigar smoking in the past 12 months? Would you describe it as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO D ... 6 |
| DSMTOBW | C. | In the past 12 months, when you were smoking cigars (FREQUENCY IN B), how many would you usually smoke in a day? IF MORE THAN 95, CODE 96. | # CIGARS ____/____ |
| | D. | When was the last time you had a cigar? | TODAY 1 YESTERDAY 2 2 TO 6 DAYS AGO 3 7 TO 13 DAYS AGO 4 14 TO 20 DAYS AGO 5 21 TO 30 DAYS AGO 6 MORE THAN A MONTH AGO. .CODE REC BELOW ... 7 |
| | | | ____/____ MONTH AGE |

| | | |
|--------------------|---|--|
| DSMTOBA DSMTOBW | B4. IF B3A CODED NO, GO TO A. Has there been a time in your life when you smoked more cigars than you did in the past 12 months? | NO GO TO E 1 YES 5 |
| DSMTOBA DSMTOBW | A. In your period of heaviest cigar smoking, would you describe your pattern of cigar smoking as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO F ... 6 |
| DSMTOBW | B. During that time when you were smoking cigars (FREQUENCY IN A), how many would you usually smoke in a day? IF MORE THAN 95, CODE 96. | # CIGARS ___/___ |
| | C. How old were you when you started smoking (AMOUNT IN B) cigars (FREQUENCY IN A)? | AGE ___/___ |
| | D. What is the longest period you smoked (AMOUNT IN B) cigars (FREQUENCY IN A)? ENTER DURATION AND CIRCLE UNIT. | ___/___ DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 |
| | E. IF B3B=6 AND B4=NO, GO TO F. During your period of heaviest cigar smoking, how soon after waking up did you have your first cigar? Was it usually within the first ... | 5 minutes? 1 30 minutes? 2 Hour? 3 Later than that? 4 |
| | F. How old were you the first time you smoked a cigar? | AGE ___/___ |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS,
CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION B

| | | | |
|--------------------|-----|---|---|
| | B5. | Have you smoked tobacco in a pipe more than 5 times in your life? | NO ... GO TO B7 1 YES 5 |
| DSMTOBA DSMTOBW | A. | Have you smoked a pipe in the past 12 months? | NO ... GO TO D 1 YES 5 |
| DSMTOBA DSMTOBW | B. | How would you describe your usual pattern of pipe smoking in the past 12 months? Would you describe it as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO D ... 6 |
| DSMTOBW | C. | In the past 12 months, when you were smoking a pipe (FREQUENCY IN B), how many pipefuls would you usually smoke in a day? IF MORE THAN 95, CODE 96. | # PIPEFULS ____/____ |
| | D. | When was the last time you smoked a pipe? | TODAY 1 YESTERDAY 2 2 TO 6 DAYS AGO 3 7 TO 13 DAYS AGO 4 14 TO 20 DAYS AGO 5 21 TO 30 DAYS AGO 6 MORE THAN A MONTH AGO. .CODE REC BELOW .. 7 |
| | | | ____/____ MONTH AGE |

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Refused = 97, Don't Know = 98

| | | |
|--------------------|--|---|
| DSMTOBA DSMTOBW | B6. IF B5A CODED NO, GO TO A. Has there been a time in your life when you smoked a pipe more than you did in the past 12 months? | NO GO TO E 1 YES 5 |
| DSMTOBA DSMTOBW | A. In your period of heaviest pipe smoking, would you describe your pattern of pipe smoking as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? . . GO TO F . . . 6 |
| DSMTOBW | B. During that time when you were smoked a pipe (FREQUENCY IN A), how many pipefuls would you usually smoke in a day? IF MORE THAN 95, CODE 96. | # PIPEFULS ____/____ |
| | C. How old were you when you started smoking (AMOUNT IN B) pipefuls (FREQUENCY IN A)? | AGE ____/____ |
| | D. What is the longest period you smoked (AMOUNT IN B) pipefuls (FREQUENCY IN A)? ENTER DURATION AND CIRCLE UNIT. | ____/____ DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 |
| | E. IF B5B=6 AND B6=NO, GO TO F. During your period of heaviest pipe smoking, how soon after waking up did you light your first pipe? Was it usually within the first. . . | 5 minutes? 1 30 minutes? 2 Hour? 3 Later than that? 4 |
| | F. How old were you the first time you smoked a pipe? | AGE ____/____ |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS,
CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION B

| | | | |
|--------------------|-----|---|---|
| | B7. | Have you used snuff or chewed tobacco more than 5 times in your life? | NO ... GO TO B9 1 YES 5 |
| DSMTOBA DSMTOBW | A. | Have you used snuff or chewing tobacco in the past 12 months? | NO ... GO TO D 1 YES 5 |
| DSMTOBA DSMTOBW | B. | How would you describe your usual pattern of using snuff or chewing tobacco in the past 12 months? Would you describe it as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO D ... 6 |
| DSMTOBW | C. | In the past 12 months, when you were using snuff or chewing tobacco (FREQUENCY IN B), how many pinches of snuff or chews of tobacco would you usually use in a day? IF MORE THAN 95, CODE 96. | # PINCHES/ CHEWS ___/___ |
| | D. | When was the last time you used snuff or chewed tobacco? | TODAY 1 YESTERDAY 2 2 TO 6 DAYS AGO 3 7 TO 13 DAYS AGO 4 14 TO 20 DAYS AGO 5 21 TO 30 DAYS AGO 6 MORE THAN A MONTH AGO. .CODE REC BELOW .. 7 ___/___ ___/___ MONTH AGE |

| | | |
|--------------------|--|--|
| DSMTOBA DSMTOBW | B8. IF B7A CODED NO, GO TO A. Has there been a time in your life when you used more snuff or chewed more tobacco than you did in the past 12 months? | NO GO TO E 1 YES 5 |
| DSMTOBA DSMTOBW | A. In your period of heaviest snuff or chewing tobacco use, would you describe your pattern of use as ... | Every day? 1 5 or 6 days a week? 2 3 or 4 days a week? 3 1 or 2 days a week? 4 1 to 3 days a month? 5 Less than once a month? .. GO TO F ... 6 |
| DSMTOBW | B. During that time when you were using snuff or chewing tobacco (FREQUENCY IN A), how many pinches or chews would you usually use in a day? | # PINCHES/ CHEWS ___/___ |
| | C. How old were you when you started using (AMOUNT IN B) pinches/chews (FREQUENCY IN A)? | AGE ___/___ |
| | D. What is the longest period you used (AMOUNT IN B) pinches/chews (FREQUENCY IN A)? ENTER DURATION AND CIRCLE UNIT. | ___/___ DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 |
| | E. IF B7B=6 AND B8=NO, GO TO F. During your period of heaviest use of snuff or chewing tobacco, how soon after waking up did you first use it? Was it usually within the first. . . | 5 minutes? 1 30 minutes? 2 Hour? 3 Later than that? 4 |
| | F. How old were you the first time you used snuff or chewed tobacco? | AGE ___/___ |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS,
CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION B

| | | | | |
|--|------|---|--|---|
| | B9. | IF B1, B3, B5, AND B7 ALL CODED NO, GO TO C1. | | |
| | | From the time you started (smoking/using tobacco) up to now, what is the longest period of time you have gone without (smoking/using tobacco)? | DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 | ___/___ |
| | | ENTER DURATION AND CIRCLE UNIT. IF NEVER FOR AN ENTIRE DAY, ENTER 00 AND CIRCLE DAYS. | | |
| | A. | Did you ever feel that you needed (a cigarette/a cigar/a pipe/chewing tobacco or snuff) to help you function? | NO 1 YES 5 | |
| TD45 TDICD5 TD3RA3 | B10. | Now I'll ask you about problems or experiences you may have had as a result of your tobacco use. | | |
| | | Have you frequently made special trips to a store, gone out of your way to get tobacco, or planned ahead so you wouldn't run out of tobacco? | NO 1 YES . . .GO TO REC .. 5*† | |
| TD45 TD3RA3 TDICD5 | A. | IF B1, B3, OR B5 CODED YES, CONTINUE. OTHERS GO TO B11. Have you often chain-smoked, that is, smoked one (cigarette/cigar/pipeful) right after another? | NO ... GO TO B11 ... 1 YES 5*† | |
| MONTH TOB4SR TOB3RMR TDICDMR AGE TOB4SR TOB3RAR TDICDAR | REC: | When was the last time you (made special trips or planned ahead so you wouldn't run out of tobacco/chain-smoked)? | | ___/___ MONTH AGE |
| TOB4SO TOBRAO TDICDAO | ONS: | How old were you the first time? | | ___/___ AGE |

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Refused = 97, Don't Know = 98

| | | | |
|--|------|---|--|
| TD41 TDICD4 TD3RA7 | B11. | After you had been (smoking/using tobacco) for a while, did you find you needed to (smoke/use) much more than you used to? | NO 1 YES .. GO TO ONS ... 5*† |
| TD41 TDICD4 TD3RA7 | A. | After you had been (smoking/using tobacco) for a while, did you find that (smoking/using) the same amount had much less effect on you? | NO ... GO TO B12 ... 1 YES 5*† |
| TOB4SO TOB3RAO TDICDAO | ONS: | How old were you the first time you (found you needed to [smoke/use] much more than you used to/found that tobacco had much less effect on you)? | ____/____ AGE |
| <u>MONTH</u> TOB4SR TOB3RMR TDICDMR <u>AGE</u> TOB4SR TOB3RAR TDICDAR | REC: | Do you still find that (you need to [smoke/use] much more than you used to/tobacco has much less effect on you)? IF YES, CODE MONTH=00. IF NO, ASK: When was the last time? | ____/____ MONTH ____/____ AGE |
| TD43 TDICD2 TD3RA1 | B12. | Have you often (smoked more/used more tobacco) than you intended? | NO ... GO TO B13 ... 1 YES 5*† |
| <u>MONTH</u> TOB4SR TOB3RMR TDICDMR <u>AGE</u> TOB4SR TOB3RAR TDICDAR | REC: | When was the last time that happened? | ____/____ MONTH ____/____ AGE |
| TOB4SO TOB3RAO TDICDAO | ONS: | How old were you the first time? | ____/____ AGE |
| TD44 TDICD2 TD3RA2 | B13. | Has there ever been a period of time when you wanted to quit or cut down on (smoking/using tobacco)? | NO ... GO TO B14 ... 1 YES 5*† |
| <u>MONTH</u> TOB4SR TOB3RMR TDICDMR <u>AGE</u> TOB4SR TOB3RAR TDICDAR | REC: | When was the last time you wanted to quit or cut down? | ____/____ MONTH ____/____ AGE |
| TOB4SO TOB3RAO TDICDAO | ONS: | How old were you the first time? | ____/____ AGE |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS, CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION B

| | | | | |
|--|------|--|---|----------------|
| | B14. | Have you ever tried to quit or cut down on (smoking/using tobacco)? | NO ... GO TO B16 1 YES 5 | |
| | A. | Have you ever: | | NO YES |
| | 1. | gone to a class to help you quit or cut down on tobacco? | 1 | 5 |
| | 2. | tried nicotine gum, spray, or patch? | 1 | 5 |
| | 3. | tried hypnosis? | 1 | 5 |
| | 4. | tried acupuncture? | 1 | 5 |
| | 5. | tried any other form of treatment to quit or cut down on your tobacco use? (SPECIFY)_____ | 1 | 5 |
| TD3RA2 | B15. | When you decided to quit or cut down on (smoking/using tobacco), were you always able to do so for at least one month? | NO 1 YES .. GO TO B16 ... 5 | |
| TD44 TDICD2 DSMTOBB | A. | Was there more than one time when you couldn't quit or cut down for at least one month? | NO 1 YES 5*† | |
| <u>MONTH</u> TOB4SR DSMTOBPY DSMTOBRE TOB3RMR TDICDMR <u>AGE</u> TOB4SR TOB3RAR TDICDAR | REC: | When was the last time you couldn't quit or cut down for at least a month? | ___/___ MONTH | ___/___ AGE |
| TOB4SO DSMTOBON TOB3RAO TDICDAO | ONS: | How old were you the first time you couldn't quit or cut down for at least a month? | | ___/___ AGE |

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Refused = 97, Don't Know = 98

B16. IF B13 OR B14 = YES, CONTINUE. OTHERS GO TO B17.

Here is a list of reasons people want to quit or try to quit (smoking/using tobacco). HAND CARD 2 TO R. Which one of these reasons made you want to quit or try to quit the most recent time?

REASON
CODE

- 1 = A doctor or nurse advised you to
- 2 = Your family or friends asked you to
- 3 = It cost too much
- 4 = You got tired of it
- 5 = It's bad for you
- 6 = It caused unpleasant side effects
- 7 = It was too inconvenient to continue
- 8 = Pregnancy
- 9 = OTHER (SPECIFY)_____

IF R SAYS NONE APPLY, ASK:

What did make you want to quit or try to quit?

RECORD RESPONSE IN 9, AND GO TO B17.

| | | |
|------|---|--|
| B17. | In the past 12 months, did you seek help from a doctor or other health professional for any problems related to your tobacco use? | NO 1 YES .. GO TO B18 5 |
| A. | Have you <u>ever</u> talked to a doctor or health professional about any problems from tobacco use? | NO 1 YES 5 |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS, CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION B

| TD42 | TDICD3 | TD3RA8 | TOWTHSX | B18. People have told us about a number of withdrawal symptoms they experienced when they've gone without tobacco. Within 24 hours of not using tobacco: | NO | YES |
|--|--------|--------|---------|--|----|-----|
| X | | X | | 1) <u>did your heart slow down?</u> | 1 | 5 |
| X | X | | | 2) <u>did you have trouble sleeping?</u> | 1 | 5 |
| X | X | X | X | 3) <u>did you feel irritable, angry or frustrated?</u> . . | 1 | 5 |
| X | X | X | X | 4) . . . <u>feel anxious or nervous?</u> | 1 | 5 |
| X | X | X | X | 5) . . . <u>have trouble concentrating?</u> | 1 | 5 |
| X | X | X | X | 6) <u>were you restless?</u> | 1 | 5 |
| X | X | X | | 7) <u>did your appetite increase or did you gain weight?</u> | 1 | 5 |
| X | X | | | 8) <u>did you feel depressed?</u> | 1 | 5 |
| | X | X | X | 9) <u>did you crave tobacco?</u> | 1 | 5 |
| | X | | | 10) . . . <u>feel weak?</u> | 1 | 5 |
| | X | | | 11) . . . <u>have a persistent cough?</u> | 1 | 5 |
| | X | | | 12) . . . <u>get mouth sores?</u> | 1 | 5 |
| | | | X | 13) <u>did you have headaches?</u> | 1 | 5 |
| | | | X | 14) . . . <u>feel drowsy?</u> | 1 | 5 |
| | | | X | 15) . . . <u>have an upset stomach?</u> | 1 | 5 |
| IF 1-15 ALL CODED NO, GO TO B19. | | | | | | |
| A. ARE 4 OR MORE ITEMS CODED YES IN 1-8? | | | | NO GO TO B | 1 | 5 |
| | | | | YES | 5 | |
| A1. You said that within 24 hours of not using tobacco (LIST ITEMS CODED YES IN 1-8). Did you have at least 4 of these symptoms at the same time? | | | | NO | 1 | |
| | | | | YES. . CODE 5 IN B1 AND GO TO B19 . . 5* | | |
| B. ARE 2 OR MORE ITEMS CODED YES IN 2-12? | | | | NO . . . GO TO B19 | 1 | 5 |
| | | | | YES | 5 | |
| B1. (This question is similar to the previous question.) You said that when you have gone without tobacco (LIST ITEMS CODED YES IN 2-12). Did you have (both/at least 2) of these symptoms at the same time? | | | | NO | 1 | |
| | | | | YES | 5† | |

| | | | |
|--|------|---|---|
| TD42 TDICD3B TD3RA9 | B19. | Have you ever (smoked/used tobacco) to avoid or get rid of withdrawal symptoms? | NO 1 YES 5*† |
| | B20. | IS B19 CODED NO <u>AND</u> ARE THERE LESS THAN 2 ITEMS CODED YES IN B18 1-15? | NO 1 YES .. GO TO B21 5 |
| MONTH TOB4SR DSMTOBPY DSMTOBRE TOB3RMR TDICDMR AGE TOB4SR TOB3RAR TDICDAR | | REC: When was the last time you (had withdrawal symptoms when you went without tobacco/(or) used tobacco to avoid or get rid of withdrawal symptoms)? | ____/____ MONTH AGE |
| TOB4SO DSMTOBON TOB3RAO TDICDAO | | ONS: How old were you the first time? | ____/____ AGE |
| TICDHM | B21. | Did (smoking/using tobacco) ever cause you to have heart trouble, emphysema, bronchitis, cancer, a persistent cough, or any other serious health problem? | NO ... GO TO B22 ... 1 YES 5 |
| TD47 TDICD6 TD3RA6 DSMTOBB | A. | Did you continue to (smoke/use tobacco) after you realized it caused you to have a health problem? | NO 1 YES 5*† |
| TD47 TDICD6 TD3RA6 DSMTOBB | B22. | Did you ever continue to (smoke/use tobacco) after you realized it made a serious illness worse? | NO 1 YES 5*† |
| TICDHM | B23. | Did (smoking/using tobacco) make you nervous, irritable, or jittery, or cause you any other emotional or mental problems? | NO ... GO TO B24 ... 1 YES 5 |
| TD47 TDICD6 TD3RA6 | A. | Did you continue to (smoke/use tobacco) after you realized it caused you emotional or mental problems? | NO 1 YES 5*† |

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SECTION B

| | | | |
|--|------|---|---|
| | B24. | IS B21A <u>OR</u> B22 <u>OR</u> B23A CODED YES? | NO ... GO TO B26 ... 1 YES 5 |
| <u>MONTH</u> TOB4SR DSMTOBPY DSMTOBRE TOB3RMR TDICDMR | B25. | REC: When was the last time you continued to (smoke/use tobacco) after you realized it was related to a (physical/mental) health problem? | ___/___ MONTH AGE |
| <u>AGE</u> TOB4SR TOB3RAR TDICDAR | | ONS: How old were you the first time? | ___/___ AGE |
| TOB4SO DSMTOBON TOB3RAO TDICDAO | | | |
| TDICD1 | B26. | Other than times you were trying to quit or cut down, have you had a strong desire or craving for tobacco? | NO ... GO TO B27 1 YES 5† |
| <u>MONTH</u> TDICDMR | | REC: When was the last time? | ___/___ MONTH AGE |
| <u>AGE</u> TDICDAR | | ONS: How old were you the first time? | ___/___ AGE |
| TDICDAO | | | |
| TD46 TDICD5 TD3RA5 | B27. | IF R ONLY USED SMOKELESS TOBACCO (B1, B3, B5 = NO AND B7 = YES), GO TO B28. More public places are adopting "NO SMOKING" policies, and more people are objecting to second-hand smoke. Have you sometimes given up or cut down on doing things, being with people, or going places because you wouldn't be able to smoke? | NO ... GO TO B28 ... 1 YES 5*† |
| <u>MONTH</u> TOB4SR TOB3RMR TDICDMR | | REC: When was the last time you gave up or reduced important activities because you wouldn't be able to smoke? | ___/___ MONTH AGE |
| <u>AGE</u> TOB4SR TOB3RAR TDICDAR | | ONS: How old were you the first time? | ___/___ AGE |
| TOB4SO TOB3RAO TDICDAO | | | |

| | | | |
|-------------------|------|---|--|
| | B28. | ON CARD 3, CIRCLE THE ITEMS CODED 5* IN B10-B27 AND CHECK THE SMALL BOXES WHERE THERE ARE CIRCLED ITEMS. ARE THERE 3 OR MORE SMALL BOXES CHECKED? | NO ... GO TO B31 1 YES 5 |
| | B29. | HAND CARD 3 TO R. You mentioned that you (LIST CIRCLED ITEMS ON CARD 3). For the purpose of this interview, each box on this card represents <u>one</u> experience, even when more than one item is circled in a box. You have reported (# OF BOXES CHECKED) experiences. | |
| TD4CLS | | Did at least three of these (# OF BOXES CHECKED) experiences ever occur together within the same 12-month period? | NO ... GO TO B31 1 YES 5 |
| TOB4PY TOB4REC | | REC: How old were you the last time at least three of these (# OF BOXES CHECKED) experiences occurred together within the same 12-month period? | ___/___ AGE |
| TOB4ONS | | ONS: How old were you the first time? | ___/___ AGE |

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SECTION B

B30. IF ONS AGE WITHIN 2 YEARS OF REC AGE IN B29, GO TO B31. OTHERS CONTINUE:

REM: You said you were (ONS AGE) when you first had three or more of these experiences together within the same 12-month period. You were (REC AGE) the last time three or more of these experiences occurred together within the same 12-month period. Between these ages, has there been at least a year when none of these experiences occurred at all?

NO GO TO B31 1
 YES 5

A. Between what ages did you have none of these experiences? _____/_____
 FROM AGE TO AGE

B. Any other ages? _____/_____
 IF "NO," CODE 00 IN "FROM AGE." FROM AGE TO AGE

C. DID R MENTION MORE THAN 2 REMISSIONS? NO 1
 YES 5

B31. ON CARD 4, CIRCLE THE ITEMS CODED 5† IN B10-B27 AND CHECK THE SMALL BOXES WHERE THERE ARE CIRCLED ITEMS. ARE THERE 3 OR MORE SMALL BOXES CHECKED?

NO GO TO C1 1
 YES 5

B32. HAND CARD 4 TO R.
 You mentioned that you (LIST CIRCLED ITEMS ON CARD 4). (This question is similar to a previous one.) For the purpose of this interview, each box on this card represents one experience, even when more than one item is circled in a box. You have reported (# OF BOXES CHECKED) experiences.

TDICDCLS Did at least three of these (# OF BOXES CHECKED) experiences ever occur together several times within a 12-month period? NO GO TO A 1
 YESGO TO REC 5

TDICDCLS A. Did at least three of these (# OF BOXES CHECKED) experiences ever occur together for at least a month? NO GO TO C1 1
 YES 5

REC: How old were you the last time (at least three of these experiences occurred together several times within a 12-month period/at least three of these experiences occurred together for at least a month? _____/
 AGE

ONS: How old were you the first time? _____/
 AGE

SECTION C

- C1. Now I'm going to ask you some questions about your use of alcohol like beer, wine, wine coolers, or hard liquor like vodka, gin, or whiskey. Each can or bottle of beer, glass of wine or wine cooler, shot of hard liquor or mixed drink with liquor counts as one drink.
- A. When was the last time you had at least one drink? Was it:
- | | | |
|---|-----------------------|---|
| in the past 7 days? | GO TO C2A | 1 |
| not in the past 7 days, but in the past 30 days? | GO TO C3A | 2 |
| more than 30 days ago, but in the past 12 months? | GO TO B | 3 |
| more than 12 months ago? | GO TO C | 4 |
| or never? | GO TO SECTION D | 5 |
- B. What month was that?
- _/_/
MONTH
- GO TO C3A.
- C. How old were you then?
- _/_/
AGE
- GO TO C5A.

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Refused = 97, Don't Know = 98

SECTION C

- C2. A. The next questions are about your use of alcohol in the past week. What did you have to drink yesterday and how much did you drink of each type of alcohol? Use this card as a guide. **HAND CARD 5 TO R. CODE NUMBER OF DRINKS BELOW FOR EACH TYPE OF ALCOHOL FOR THAT DAY USING CARD 5, THEN ASK:**
Anything else?
- B. What about the day before that, on (DAY), what did you have and how much did you drink of each type of alcohol? **CODE NUMBER OF DRINKS BELOW FOR EACH TYPE OF ALCOHOL FOR THAT DAY USING CARD 5, THEN ASK:** Anything else?
- C. REPEAT B TO COMPLETE THE PAST SEVEN DAYS.
- D. TOTAL EACH COLUMN AND ROW.

| | BEER | WINE | HARD LIQUOR ALONE OR IN A DRINK | TOTAL |
|--------------|---------|---------|---------------------------------------|-----------|
| MONDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| TUESDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| WEDNESDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| THURSDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| FRIDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| SATURDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| SUNDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| TOTAL | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| | | | | Past Week |

IF CURRENT MONTH, CODE MONTH = 00. IF **NOT** IN PAST 12 MONTHS, CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

- C3. Was your use of alcohol this past week pretty much like your weekly use of alcohol in the past 12 months? NO 1
YES GO TO C4 5
- A. Now I want to ask you about how much you would usually drink in a week, during weeks when you were drinking in the past 12 months. For example, about how much beer, wine, and liquor would you usually have on the weekdays, from Monday through Thursday, in total? Use this card as a guide. **HAND CARD 5 TO R. CODE NUMBER OF DRINKS MONDAY-THURSDAY BELOW FOR EACH TYPE. IF MORE THAN 95, CODE 96.**
- B. About how much beer, wine and liquor would you usually drink on the weekends, from Friday through Sunday, in total? **CODE NUMBER OF DRINKS FRIDAY-SUNDAY BELOW FOR EACH TYPE. IF MORE THAN 95, CODE 96.**
- C. **TOTAL EACH COLUMN AND ROW.**

| | BEER | WINE | HARD LIQUOR ALONE OR IN A DRINK | TOTAL |
|---------------------|---------|---------|---------------------------------------|-----------------------|
| MONDAY- THURSDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| FRIDAY- SUNDAY | ___ ___ | ___ ___ | ___ ___ | = ___ ___ |
| TOTAL | ___ ___ | ___ ___ | ___ ___ | = ___ ___ Per Week |

- C4. How many weeks in the past 12 months did you drink at all? Would you say:
- Almost every week (48 to 52 weeks)? 1
 More weeks than not (30 to 47 weeks)? 2
 About half the weeks (23 to 29 weeks)? 3
 At least one week a month (12 to 23 weeks)? 4
 Less than one week a month? 5

SECTION C

C5. Has there ever been a time in your life when you drank more than you did in the past 12 months? NO GO TO C6 1
YES 5

A. Think about the time when you were drinking the most. How old were you when that started? /
AGE

B. Now I want to ask you about how much you would usually drink during that time when you were drinking the most. How much beer, wine, and liquor would you usually have during the weekdays, from Monday through Thursday, in total? Use this card as a guide. HAND CARD 5 TO R. CODE NUMBER OF DRINKS MONDAY-THURSDAY BELOW FOR EACH TYPE. IF MORE THAN 95, CODE 96.

C. About how much beer, wine and liquor would you usually drink on the weekends, from Friday through Sunday, in total? CODE NUMBER OF DRINKS FRIDAY-SUNDAY BELOW FOR EACH TYPE. IF MORE THAN 95, CODE 96.

D. TOTAL THE COLUMNS AND ROWS.

| | BEER | WINE | HARD LIQUOR ALONE OR IN A DRINK | TOTAL |
|---------------------|----------------------------------|----------------------------------|---------------------------------------|--|
| MONDAY- THURSDAY | <u> </u> <u> </u> | <u> </u> <u> </u> | <u> </u> <u> </u> | = <u> </u> <u> </u> <u> </u> |
| FRIDAY- SUNDAY | <u> </u> <u> </u> | <u> </u> <u> </u> | <u> </u> <u> </u> | = <u> </u> <u> </u> <u> </u> |
| TOTAL | <u> </u> <u> </u> <u> </u> | <u> </u> <u> </u> <u> </u> | <u> </u> <u> </u> <u> </u> | = <u> </u> <u> </u> <u> </u> per week |

E. You said your period of heaviest drinking started at age (AGE IN C5A). How long did that last? /
ENTER DURATION AND CIRCLE UNIT. DAYS 1
WEEKS 2
MONTHS 3
YEARS 4

C6. How old were you the first time you had a drink, not just sips from someone else's drink? /
AGE

A. At what age did you begin to drink regularly-- that is, drinking at least once a month for several months in a row? IF NEVER, RECORD 00. /
AGE

B. How old were you the first time you got drunk? RECORD AGE, GO TO D. IF NEVER, RECORD 00 AND GO TO C7. IF DK, RECORD 98 AND ASK C. /
AGE

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| | | | | | |
|--|------|---|---------------|---------------------|---------|
| | C. | Was it before you were 15 years old? | NO | GO TO E | 1 |
| | | | YES | | 5 |
| | D. | IF A IS <15 OR C = YES, ASK: Did you get drunk more than once before you were 15? | NO | | 1 |
| | | | YES | | 5 |
| DSMALCAA | E. | Have you ever kept drinking for a couple of days or more without sobering up? | NO | (GO TO F) | 1 |
| | | | YES | | 5 |
| DSMALCMR DSMALCAR | REC: | When was the last time? | ___/___ | | ___/___ |
| | | | MONTH | | AGE |
| DSMALCAO | ONS: | How old were you the first time? | | | ___/___ |
| | | | | | AGE |
| | F. | IN C2, IF TOTAL NUMBER OF DRINKS = 20 OR MORE ON AT LEAST 2 DAYS, CODE F AND G YES WITHOUT ASKING. CODE 00 IN REC MONTH AND GO TO ONS. Have you ever drunk as much as 20 drinks in one day — that would be about a fifth of liquor, or 3 bottles of wine, or as much as 3 six-packs of beer? | NO | GO TO C7 | 1 |
| | | | YES | | 5 |
| DSMALCAA | G. | Have you done this more than once? | NO | | 1 |
| | | | YES | | 5 |
| DSMALCMR DSMALCAR | REC: | When was the last time? | ___/___ | | ___/___ |
| | | | MONTH | | AGE |
| DSMALCAO | ONS: | How old were you the first time you drank 20 or more drinks in one day? | | | ___/___ |
| | | | | | AGE |
| <hr/> | | | | | |
| | C7. | Did drinking ever cause you to have: | <u>NO</u> | <u>YES</u> | |
| DSMALCAB | 1) | <u>problems with your family?</u> | 1 | 5 | |
| DSMALCAB | 2) | <u>problems with your friends?</u> | 1 | 5 | |
| DSMALCAB | 3) | <u>problems with people at work or school?</u> | 1 | 5 | |
| DSMALCAB | 4) | Did you ever get into <u>physical fights</u> while drinking? | 1 | 5 | |
| AA4A4 AD3RA6 AA3RA1 | A. | IF ALL CODED NO, GO TO C8A. IF ANY CODED YES, CONTINUE. Did you continue to drink after you realized drinking was causing you any of these problems? | NO | GO TO C8 | 1 |
| | | | YES | | 5 |
| MONTH ALCA4MR ALC3RMR DSMALCMR AGE ALCA4AR ALC3RAR DSMALCAR | REC: | When was the last time you continued to drink after you realized drinking caused you to have (LIST ALL CODED YES IN 1-4)? | ___/___ | | ___/___ |
| | | | MONTH | | AGE |
| ALCA4AO ALC3RAO DSMALCAO | ONS: | How old were you the first time? | | | ___/___ |
| | | | | | AGE |

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SECTION C

| | | | | |
|--|------|----|--|---|
| | C8. | A. | ARE C6A AND C6B BOTH CODED 00? | NO GO TO C9 1 YES 5 |
| | | B. | ARE C7 1-4 ALL CODED NO? | NO 1 YES GO TO D1 5 |
| | C9. | | Have you ever gone to school or work right after you had been drinking, or ever had a drink while you were at school or work? | NO 1 YES 5 |
| AICDHM | C10. | | Have you ever accidentally injured yourself while under the influence of alcohol? | NO GO TO C11 1 YES 5 |
| AD3RA4 AA3RA2 | A. | | How many times has this happened? IF MORE THAN 95, CODE 96. | ____/____ # TIMES |
| <u>MONTH</u> ALC3RMR <u>AGE</u> ALC3RAR | REC: | | When was the last time? | ____/____ MONTH AGE |
| ALC3RAO | ONS: | | How old were you the first time you accidentally injured yourself while under the influence of alcohol? | ____/____ AGE |
| | | | | GO TO C12. |
| AA4A2 AD3RA4 AA3RA2 AICDHM | C11. | | Have there been times when you drove a car right after you had been drinking or were drinking while you were driving? | NO 1 YES GO TO B 5 |
| AA4A2 AD3RA4 AA3RA2 AICDHM | A. | | Have there been times when you were under the influence of alcohol when you could have gotten yourself or others hurt, or put yourself or others at risk, including unprotected sex? | NO GO TO C12 1 YES 5 |
| | B. | | Has this happened at least twice in a 12 month period? | NO 1 YES 5 |
| <u>MONTH</u> ALCA4MR ALC3RMR <u>AGE</u> ALCA4AR ALC3RAR | REC: | | When was the last time this happened? | ____/____ MONTH AGE |
| ALCA4AO ALC3RAO | ONS: | | How old were you the first time? | ____/____ AGE |

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| | | | |
|--|---|----------------------------------|--------------------------------|
| C12. Did your drinking interfere with your responsibilities: | | <u>NO</u> | <u>YES</u> |
| AA4A1 AD3RA4 | 1) at home or with children? | 1 | 5 |
| AA4A1 AD3RA4 DSMALCAB | 2) at work? | 1 | 5 |
| AA4A1 AD3RA4 | 3) at school? | 1 | 5 |
| IF 1-3 ALL CODED NO, GO TO C13. | | | |
| | A. Did this happen more than once in any 12 month period? | NO | 1 |
| | | YES | 5 |
| <u>MONTH</u> ALCA4MR ALC3RMR DSMALCMR | REC: When was the last time drinking interfered with your responsibilities? | <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE |
| <u>AGE</u> ALCA4AR ALC3RAR DSMALCAR | | | |
| ALCA4AO ALC3RAO DSMALCAO | ONS: How old were you the first time? | | <u> </u> / <u> </u> AGE |

| | | | | |
|-------------------------------------|--|----------------------------------|-----------------|--------------------------------|
| DSMALCAB | C13. Have you had any legal problems because of your drinking, like being arrested for disturbing the peace, for driving while under the influence of alcohol, or for anything else? | NO | GO TO C14 | 1 |
| | | YES | | 5 |
| AA4A3 | A. Has this happened at least twice in a 12 month period? | NO | | 1 |
| | | YES | | 5 |
| <u>MONTH</u> ALCA4MR DSMALCMR | REC: When was the last time? | <u> </u> / <u> </u> MONTH | | <u> </u> / <u> </u> AGE |
| <u>AGE</u> ALCA4AR DSMALCAR | | | | |
| ALCA4AO DSMALCAO | ONS: How old were you the first time you had legal problems because of drinking? | | | <u> </u> / <u> </u> AGE |

| | | | | |
|--------------------------|---|----------------------------------|--|--------------------------------|
| DSMALCAA AICDHM | C14. Have you ever had blackouts while drinking, when you couldn't remember afterwards what had happened? | NO | GO TO C15 | 1 |
| | | YES | | 5 |
| | A. In your lifetime, how many blackouts have you had from drinking? IF MORE THAN 95, CODE 96. | | <u> </u> / <u> </u> # BLACKOUTS | |
| <u>MONTH</u> DSMALCMR | REC: When was the last time? | <u> </u> / <u> </u> MONTH | | <u> </u> / <u> </u> AGE |
| <u>AGE</u> DSMALCAR | | | | |
| DSMALCAO | ONS: How old were you the first time you had a blackout? | | | <u> </u> / <u> </u> AGE |

SECTION C

| | | | |
|--|------|--|---|
| AICDD1 | C15. | Other than times when you were trying to quit or cut down, have you had a strong desire or urge to drink? | NO GO TO C16 1 YES 5*† |
| <u>MONTH</u> AICDMR <u>AGE</u> AICDAR | REC: | When was the last time? | ___/___ MONTH AGE |
| AICDAO | ONS: | How old were you the first time you felt such a strong desire to drink? | ___/___ AGE |
| AD43 AD3RA1 AICDD2 | C16. | Have you often had more to drink than you intended? | NO 1 YES GO TO REC 5*† |
| AD43 AD3RA1 AICDD2 | A. | Have you often kept drinking longer than you intended? | NO GO TO C17 1 YES 5*† |
| <u>MONTH</u> ALCD4MR ALC3RMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR AICDAR | REC: | When was the last time? | ___/___ MONTH AGE |
| ALCD4AO ALC3RAO AICDAO | ONS: | How old were you the first time you (had more to drink/kept drinking longer) than you intended? | ___/___ AGE |
| AD41 AD3RA7 DSMALCB AICDD4 | C17. | Have you ever found that you had to drink much more than you used to in order to get the effect you wanted? | NO 1 YES GO TO ONS 5*† |
| AD41 AD3RA7 DSMALCB AICDD4 | A. | Did you ever find that the same amount of alcohol had much less effect on you than it once did? | NO GO TO C18 1 YES 5*† |
| ALCD4AO ALC3RAO DSMALCAO AICDAO | ONS: | How old were you the first time? | ___/___ AGE |
| <u>MONTH</u> ALCD4MR ALC3RMR DSMALCMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR DSMALCAR AICDAR | REC: | Do you still find that (you have to drink much more than you used to to get the effect/the same amount has much less effect)? IF YES, CODE MONTH=00. IF NO, ASK: When was the last time? | ___/___ MONTH AGE |

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CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

| | | | |
|--|------|---|---|
| AD44 AD3RA2 AICDD2 | C18. | Has there ever been a period of time when you wanted to quit or cut down on drinking? | NO GO TO C19 1 YES 5*† |
| MONTH ALCD4MR ALC3RMR AICDMR AGE ALCD4AR ALC3RAR AICDAR | REC: | When was the last time? | ____/____ MONTH AGE |
| ALCD4AO ALC3RAO AICDAO | ONS: | How old were you the first time? | ____/____ AGE |
| | C19. | Have you ever tried to quit or cut down on your drinking? | NO 1 YES 5 |
| | A. | Have you ever attended AA, been in an alcohol treatment program or used any other treatment for your drinking? INCLUDE CURRENT TREATMENT. | NO 1 YES 5 |
| AD3RA2 DSMALCAA | C20. | IF C19=NO, GO TO C22. When you decided to quit or cut down on drinking were you always able to do so for at least a month? | NO 1 YES GO TO C21 5 |
| AD44 AICDD2 | A. | Was there more than one time when you were unable to quit or cut down for at least a month? | NO 1 YES 5*† |
| MONTH AICDMR ALCD4MR ALC3RMR DSMALCMR AGE AICDAR ALCD4AR ALC3RAR DSMALCAR | REC: | When was the last time you were unable to quit or cut down for at least a month? | ____/____ MONTH AGE |
| ALCD4AO ALC3RAO DSMALCAO AICDAO | ONS: | How old were you the first time? | ____/____ AGE |

SECTION C

C21. IF C18 OR C19 = YES, CONTINUE.
OTHERS GO TO C22.

Here is a list of reasons people want to quit or try to quit drinking. HAND CARD 6 TO R. Which one of these reasons made you want to quit or try to quit the most recent time?

REASON
CODE

- 1 = A doctor or nurse advised you to
- 2 = Your family or friends asked you to
- 3 = It cost too much
- 4 = You got tired of it
- 5 = Drinking is bad for you
- 6 = It caused unpleasant side effects
- 7 = Pregnancy
- 8 = Legal problems
- 9 = OTHER (SPECIFY) _____

IF R SAYS NONE ON THE LIST, ASK:

What did make you want to quit or try to quit?
RECORD RESPONSE IN 9, AND GO TO C22.

C22. In the past 12 months, did you seek help from a doctor or other health professional for any problems related to your alcohol use? NO 1
YES GO TO C23 5

A. Have you ever talked to a doctor or health professional about any problems from drinking? NO 1
YES 5

C23. From the time you first began drinking, up to now, what is the longest period of time you've gone without a drink? ENTER DURATION AND CIRCLE UNIT. IF NEVER FOR AN ENTIRE DAY, CODE 00 DAYS. _____/_____
DAYS 1
WEEKS 2
MONTHS 3
YEARS 4

DSMALCAA C24. Have you found it necessary to make rules for yourself to control your drinking, like not drinking before a certain time of day, not drinking on certain days of the week, or anything else? NO GO TO C25 1
YES 5

REC: When was the last time you made rules to limit your drinking? _____/_____
MONTH AGE

ONS: How old were you the first time? _____/_____
AGE

MONTH
DSMALCMR
AGE
DSMALCAR
DSMALCAO

| | | |
|--|--|---|
| AD45 AD3RA3 AICDD5 | C25. Has there ever been a period when you spent a lot of time drinking, planning how you would get alcohol, or recovering from a hangover? | NO GO TO C26 1 YES 5*† |
| <u>MONTH</u> ALCD4MR ALC3RMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR AICDAR | REC: When was the last time? | ____/____ MONTH AGE |
| ALCD4AO ALC3RAO AICDAO | ONS: How old were you the first time? | ____/____ AGE |
| AD46 AD3RA5 AICDD5 | C26. Did you give up or reduce any important activities that would interfere with your drinking like getting together with friends or relatives, going to work or school, participating in sports, or anything else? | NO GO TO C27 1 YES 5*† |
| <u>MONTH</u> ALCD4MR ALC3RMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR AICDAR | REC: When was the last time you gave up or reduced important activities because of drinking? | ____/____ MONTH AGE |
| ALCD4AO ALC3RAO AICDAO | ONS: How old were you the first time? | ____/____ AGE |

SECTION C

| AD42 | AICDD3 | AD3RA8 | DSMALCB | | | NO | YES |
|--------------------------|--------|--------|---------|------|---|---|----------------|
| | | | | C27. | People have told us about a number of withdrawal symptoms they have experienced within a few hours of not drinking. During the first few hours of not drinking, did you (READ EACH AND CODE): | | |
| X | X | X | X | 1) | have the shakes? | 1 | 5 |
| X | X | X | | 2) | have difficulty getting to sleep or staying asleep? | 1 | 5 |
| X | | X | X | 3) | feel anxious? | 1 | 5 |
| X | X | X | X | 4) | sweat a lot? | 1 | 5 |
| X | X | X | X | 5) | notice your heart beating fast? | 1 | 5 |
| X | X | X | | 6) | see, feel, or hear things that other people couldn't? | 1 | 5 |
| | | | | | During the first few hours of not drinking, did you: | | |
| X | X | X | X | 7) | vomit or feel sick to your stomach? | 1 | 5 |
| X | X | | | 8) | have a seizure? | 1 | 5 |
| X | X | | | 9) | feel restless? | 1 | 5 |
| | X | X | X | 10) | feel weak? | 1 | 5 |
| | X | X | | 11) | have headaches? | 1 | 5 |
| | | X | X | 12) | feel depressed or irritable? | 1 | 5 |
| | | | | | IF 1-12 ALL CODED NO, GO TO C28. | | |
| | | | | A. | ARE 2 OR MORE CODED YES IN 1-9? | NO GO TO B 1 YES 5 | |
| DSM4 | | | | A1. | You said during the first few hours of not drinking you (LIST ITEMS CODED YES IN 1-9). Did you have (both/at least 2) of these symptoms at the same time? | NO 1 YES 5* | |
| | | | | B. | ARE 3 OR MORE CODED YES IN 1, 2, OR 4-11? | NO GO TO REC 1 YES 5 | |
| ICD | | | | B1. | (This question is similar to the previous question). You said during the first few hours of not drinking you (LIST ITEMS CODED YES IN 1, 2, OR 4-11). Did you have at least 3 of these symptoms at the same time? | NO 1 YES 5† | |
| | | | | REC: | When was the last time you had any of these symptoms during the first few hours of not drinking? | ___/___ MONTH | ___/___ AGE |
| | | | | ONS: | How old were you the first time? | | ___/___ AGE |
| AD3RA9 AICDD3 AD42 | | | | C28. | Did you ever drink or take a tranquilizer or sedative to avoid (or get rid of) withdrawal symptoms? | NO GO TO C29 1 YES 5*† | |

| | | | |
|--|---------------------------------------|------------------|----------------|
| <u>MONTH</u> ALCD4MR ALC3RMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR AICDAR ALCD4AO ALC3RAO AICDAO | REC: When was the last time? | ___/___ MONTH | ___/___ AGE |
| ALCD4AO ALC3RAO AICDAO | ONS: How old were you the first time? | | ___/___ AGE |

| | | | | |
|--|------|---|-------------------------------------|------------|
| AICDHM | C29. | Did drinking ever cause you to have any physical health problems like . . . | <u>NO</u> | <u>YES</u> |
| | | 1) cirrhosis or liver disease? | 1 | 5 |
| | | 2) stomach disease or ulcers or vomiting blood? | 1 | 5 |
| | | 3) tingling or numbness in your hands or feet? | 1 | 5 |
| | | 4) memory problems? | 1 | 5 |
| | | 5) pancreatitis? | 1 | 5 |
| AD47 AD3RA6 AA3RA1 DSMALCAA AICDD6 | A. | IF 1-5 ALL CODED NO, GO TO C30. OTHERS ASK: Did you continue to drink after you realized that drinking was causing you any of these health problems? | NO 1 YES 5*† | |

| | | | | |
|--|------|---|-------------------------------------|--|
| AD47 AD3RA6 AA3RA1 AICDD6 DSMALCAA | C30. | Have you ever continued to drink after you realized it made a serious physical illness worse? | NO 1 YES 5*† | |
| | | IF C29 1-5 ALL CODED NO AND C30 CODED NO, GO TO C32. | | |

| | | | | |
|--|------|--|------------------|----------------|
| <u>MONTH</u> ALCD4MR ALC3RMR DSMALCMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR DSMALCAR AICDAR ALCD4AO ALC3RAO DSMALCAO AICDAO | C31. | REC: When was the last time you continued to drink after you realized drinking was related to a physical health problem? | ___/___ MONTH | ___/___ AGE |
| ALCD4AO ALC3RAO DSMALCAO AICDAO | | ONS: How old were you the first time? | | ___/___ AGE |

| | | | | |
|--|------|---|---|----------------|
| DSMALCAA | C32. | Has there ever been a period in your life when you felt you needed alcohol to help you function--that is, you felt you could not do your work well unless you had had something to drink? | NO GO TO C33 1 YES 5 | |
| <u>MONTH</u> DSMALCMR <u>AGE</u> DSMALCAR DSMALCAO | | REC: When was the last time? | ___/___ MONTH | ___/___ AGE |
| | | ONS: How old were you the first time you felt you needed a drink to function? | | ___/___ AGE |

SECTION C

| | | | | |
|--|------|---|--------------------------|------------------|
| AICDHM | C33. | Has alcohol ever caused you emotional or psychological problems, such as: | <u>NO</u> | <u>YES</u> |
| | | 1) feeling uninterested in things? | 1 | 5 |
| | | 2) feeling depressed or sad? | 1 | 5 |
| | | 3) feeling suspicious of others or paranoid? | 1 | 5 |
| | | 4) having strange ideas? | 1 | 5 |
| | | 5) feeling very irritable? | 1 | 5 |
| | | IF 1-5 ALL CODED NO, GO TO C34. | | |
| AD47 AD3RA6 AA3RA1 AICDD6 | A. | Did you continue to drink after you realized drinking was causing any of these problems? | NO GO TO C34 | 1 5*† |
| <u>MONTH</u> ALCD4MR ALC3RMR AICDMR <u>AGE</u> ALCD4AR ALC3RAR AICDAR | REC: | When was the last time? | ____/____ MONTH | ____/____ AGE |
| ALCD4AO ALC3RAO AICDAO | ONS: | How old were you the first time you continued to drink after you realized alcohol was causing any of these emotional or psychological problems? | | ____/____ AGE |

| | | | |
|------|--|--------------------------|--------|
| C34. | ON CARD 7, CIRCLE THE ITEMS CODED 5* IN C15-C33A AND CHECK THE SMALL BOXES WHERE THERE ARE CIRCLED ITEMS. ARE THERE 3 OR MORE SMALL BOXES CHECKED? | NO GO TO C37 | 1 5 |
|------|--|--------------------------|--------|

| | | | |
|------|--|--------------------------|------------------|
| C35. | HAND CARD 7 TO R. You mentioned that you (LIST CIRCLED ITEMS ON CARD 7). For the purpose of this interview, each box on this card represents <u>one</u> experience, even when more than one item is circled in a box. You have reported (# OF BOXES CHECKED) experiences. | | |
| ALC4 | Did at least three of these (# OF BOXES CHECKED) experiences ever occur together within the same 12-month period? | NO GO TO C37 | 1 5 |
| | REC: How old were you the last time at least three of these (# OF BOXES CHECKED) experiences occurred together within the same 12-month period? | | ____/____ AGE |
| | ONS: How old were you the first time? | | ____/____ AGE |

IF CURRENT MONTH, CODE MONTH = 00. IF NOT IN PAST 12 MONTHS, CODE MONTH = 66, AND ENTER AGE. OTHERS CODE ACTUAL MONTH.

C36. IF ONS AGE WITHIN 2 YEARS OF REC AGE IN C35,
GO TO C37. OTHERS CONTINUE:

- REM: You said you were (ONS AGE) when you first had three or more of these experiences together within the same 12-month period. You were (REC AGE) the last time three or more of these experiences occurred together within the same 12-month period. Between these ages, have you had at least a year when none of these experiences occurred at all?
- NO GO TO C37 1
YES 5
- A. Between what ages did you have none of these experiences? / /
FROM AGE TO AGE
- B. Any other ages? IF "NO," CODE 00 IN "FROM AGE." / /
FROM AGE TO AGE
- C. DID R MENTION MORE THAN 2 REMISSIONS? NO 1
YES 5

C37. ON CARD 8, CIRCLE THE ITEMS CODED 5† IN C15-C33A AND CHECK THE SMALL BOXES WHERE THERE ARE CIRCLED ITEMS. ARE THERE 3 OR MORE SMALL BOXES CHECKED?

NO GO TO D1 1
YES 5

C38. HAND CARD 8 TO R.
You mentioned that you (LIST CIRCLED ITEMS ON CARD 8). (This question is similar to a previous one.) For the purpose of this interview, each box on this card represents one experience, even when more than one item is circled in a box. You have reported (# OF BOXES CHECKED) experiences.

ICD

Did at least three of these (# OF BOXES CHECKED) experiences ever occur together several times within a 12-month period?

NO GO TO A 1
YES GO TO REC 5

ICD

A. Did at least three of these (# OF BOXES CHECKED) experiences ever occur together for at least a month?

NO GO TO D1 1
YES 5

REC: How old were you the last time? /
AGE

ONS: How old were you the first time (at least three of these experiences occurred together several times within a 12-month period/at least three of these experiences occurred together for at least a month)? /
AGE

JAN = 01, FEB = 02, MAR = 03, APR = 04, MAY = 05, JUN = 06, JUL = 07, AUG = 08, SEP = 09, OCT = 10, NOV = 11, DEC = 12.
Refused = 97, Don't Know = 98

SECTION D

D1. Now I'd like to ask about your experiences with medicines and other drugs. HAND CARD 9 TO R. Look at the medicines on this card. Have you used any of these medicines more than 5 times when they were not prescribed for you, in larger amounts than prescribed, more often than prescribed, or for longer than prescribed?

NO ... GO TO D2 1
YES 5

A. Which ones? **CIRCLE NAMES IN 2, 3 OR 7 BELOW AND CODE 5 FOR THAT CATEGORY IN COLUMN A.**

D2. HAND CARD 10 TO R. Now look at the drugs on this card. Have you ever used any of these more than 5 times in your life?

NO. .GO TO INT BOX .. 1
YES 5

A. Which ones have you used more than 5 times? **CIRCLE NAMES IN 1, 2 OR 4-11 BELOW AND CODE 5 FOR THAT CATEGORY IN COLUMN A.**

| | A | | B | C | | C1 | D |
|---|----|-----|------------|--------------|---------|-------------|-------------|
| | NO | YES | ONS AGE | REC MONTH | AGE | DAYS AGO | ROUTE |
| 1) Marijuana , grass, or pot; hashish | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 2) Stimulants : amphetamines, diet pills, ice, khat, methamphetamine, Ritalin, speed, uppers | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 3) Sedatives : barbiturates, Librium, Seconal, sleeping pills, tranquilizers, Valium, Xanax | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 4) Club drugs : ecstasy or MDMA, GHB, ketamine, rohypnol | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 5) Cocaine , crack | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 6) Heroin | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 7) Opioids : codeine, Darvon, Demerol, Dilaudid, methadone, morphine, opium, Percodan, Talwin, T's & blues | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 8) PCP | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 9) Hallucinogens : DMT, LSD or acid, mescaline, mushrooms, peyote, psilocybin | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 10) Inhalants : glue, toluene, gasoline, paint, paint thinner | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |
| 11) Other : amyl nitrite or poppers, anabolic steroids, nitrous oxide, or anything else? (SPECIFY OTHER) | 1 | 5 | ___/___ | ___/___ | ___/___ | ___/___ | 1 2 3 4 5 6 |

INTERVIEWER: CODE 1 IN ALL CATEGORIES (D2 1-11) WHERE NO DRUG IS MENTIONED. IF NO 5 CODED IN COLUMN A, GO TO SECTION E. FOR EACH CATEGORY CODED 5 IN COLUMN A, CIRCLE THE CORRESPONDING DRUGS ON CARD 11.

HAND CARD 11 TO R. I have circled on this card all the medicines and drugs you have told me you used.

INCLUDE ALL DRUGS CIRCLED IN THE CATEGORIES CODED 5 WHEN ASKING B-D.

- B. How old were you the first time you used (DRUGS)? CODE IN COLUMN B.
- C. When was the last time you used (DRUGS)? CODE IN COLUMN C. IF WITHIN PAST 30 DAYS, CODE 00 AND GO TO C1; IF NOT IN PAST 30 DAYS GO TO D.
- C1. How many days ago did you use (DRUGS)? CODE IN COLUMN C1.
- D. HAND CARD 12 TO R AND ASK: Look at the list on this card and tell me all of the ways you have used (DRUGS). CODE IN COLUMN D.

GO TO B FOR NEXT DRUG CATEGORY.

CIRCLE ALL THAT APPLY IN COLUMN D.

| | |
|---|-----|
| BY MOUTH, PILLS, DRINKING OR CHEWING | = 1 |
| SMOKING OR FREEBASING | = 2 |
| SNORTING, SNIFFING, BREATHING, OR HUFFING | = 3 |
| INJECTION INTO THE VEINS (IV) | = 4 |
| INJECTION INTO THE SKIN OR MUSCLE | = 5 |
| OTHER METHODS | = 6 |

- D3. A. You said that you used (LIST ALL NAMES CIRCLED IN THAT CATEGORY. IF MORE THAN 1 DRUG IS CIRCLED IN A CATEGORY, CONTINUE. OTHERS RECORD DRUG NAME IN A AND GO TO B.) Which of these did you use the most? RECORD DRUG NAME IN A.
- B. Think about the period of time when you were using (DRUG IN A) most frequently. During that time did you use it... (READ AND CODE RESPONSE PHRASES IN B).
- C. When you were using (DRUG NAME) that frequently, how much would you usually use in a day? Please use this card to help you. HAND CARD 13 TO R. CODE IN C1 AND C2.
- D. How old were you when you first began to use (AMOUNT IN C1 AND C2) of (DRUG) (FREQUENCY IN B)? CODE IN D.
- E. What was your longest period of using (AMOUNT IN C1 AND C2) of (DRUG) (FREQUENCY IN B)? CODE IN E. GO TO A FOR NEXT DRUG CATEGORY.

A: DRUG NAME:
B: CODE FIRST YES:
1) Every day?
2) 5 or 6 days a week?
3) 3 or 4 days a week?
4) 1 or 2 days a week?
5) 1 to 3 days a month?
6) less than once a month?
(GO TO NEXT CIRCLED DRUG)

C1: QUANTITY:

C2: UNIT TYPE: (SEE "UNIT TYPE" BOX)

D: AGE ONS:

E: DURATION:
DURATION UNITS:

| | 1) Marijuana | 2) Stimulants | 3) Sedatives | 4) Club Drugs | 5) Cocaine | 6) Heroin |
|--------------------------------------|--------------|---------------|--------------|---------------|------------|-----------|
| A: DRUG NAME: | _____ | _____ | _____ | _____ | _____ | _____ |
| B: CODE FIRST YES: | | | | | | |
| 1) Every day? | 1 | 1 | 1 | 1 | 1 | 1 |
| 2) 5 or 6 days a week? | 2 | 2 | 2 | 2 | 2 | 2 |
| 3) 3 or 4 days a week? | 3 | 3 | 3 | 3 | 3 | 3 |
| 4) 1 or 2 days a week? | 4 | 4 | 4 | 4 | 4 | 4 |
| 5) 1 to 3 days a month? | 5 | 5 | 5 | 5 | 5 | 5 |
| 6) less than once a month? | 6 | 6 | 6 | 6 | 6 | 6 |
| (GO TO NEXT CIRCLED DRUG) | | | | | | |
| C1: QUANTITY: | _____ | _____ | _____ | _____ | _____ | _____ |
| C2: UNIT TYPE: (SEE "UNIT TYPE" BOX) | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| D: AGE ONS: | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| E: DURATION: | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| DURATION UNITS: | | | | | | |
| DAYS | 1 | 1 | 1 | 1 | 1 | 1 |
| WEEKS | 2 | 2 | 2 | 2 | 2 | 2 |
| MONTHS | 3 | 3 | 3 | 3 | 3 | 3 |
| YEARS | 4 | 4 | 4 | 4 | 4 | 4 |

| | 7) Opioids | 8) PCP | 9) Hallucinogens | 10) Inhalants | 11) Other | UNIT TYPE |
|--------------------------------------|----------------|----------------|------------------|----------------|----------------|--------------------|
| A: DRUG NAME: | _____ | _____ | _____ | _____ | _____ | |
| B: CODE FIRST YES: | | | | | | |
| 1) Every day? | 1 | 1 | 1 | 1 | 1 | 01=ampules |
| 2) 5 or 6 days a week? | 2 | 2 | 2 | 2 | 2 | 02=bags |
| 3) 3 or 4 days a week? | 3 | 3 | 3 | 3 | 3 | 03=blotters |
| 4) 1 or 2 days a week? | 4 | 4 | 4 | 4 | 4 | 04=blunts |
| 5) 1 to 3 days a month? | 5 | 5 | 5 | 5 | 5 | 05=breaths |
| 6) less than once a month? | 6 | 6 | 6 | 6 | 6 | 06=buttons |
| (GO TO NEXT CIRCLED DRUG) | | | | | | 07=capsules |
| | | | | | | 08=cigarettes |
| | | | | | | 09=grams |
| | | | | | | 10=hits |
| | | | | | | 11=huffs |
| | | | | | | 12=joints |
| | | | | | | 13=lines |
| | | | | | | 14=milligrams |
| | | | | | | 15=ounces |
| | | | | | | 16=panes |
| | | | | | | 17=pills |
| | | | | | | 18=pipefuls |
| | | | | | | 19=rocks |
| | | | | | | 20=sheets |
| | | | | | | 21=suppositories |
| | | | | | | 22=tablespoons |
| | | | | | | 23=teaspoons |
| | | | | | | 24=other (specify) |
| | | | | | | _____ |
| C1: QUANTITY: | _____ | _____ | _____ | _____ | _____ | |
| C2: UNIT TYPE: (SEE "UNIT TYPE" BOX) | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | |
| D: AGE ONS: | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | |
| E: DURATION: | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | |
| DURATION UNITS: | | | | | | |
| | DAYS 1 | DAYS 1 | DAYS 1 | DAYS 1 | DAYS 1 | |
| | WEEKS 2 | WEEKS 2 | WEEKS 2 | WEEKS 2 | WEEKS 2 | |
| | MONTHS 3 | MONTHS 3 | MONTHS 3 | MONTHS 3 | MONTHS 3 | |
| | YEARS 4 | YEARS 4 | YEARS 4 | YEARS 4 | YEARS 4 | |

D4. From the time you first started using (LIST ALL NAMES CIRCLED IN THE CATEGORY), up to now, what is the longest period of time you've gone without using any of them? IF NEVER FOR AN ENTIRE DAY, CODE 00 DAYS.

GO TO NEXT DRUG CATEGORY.

| | | | |
|--|---|--|---|
| <p>1) Marijuana</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>2) Stimulants</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>3) Sedatives</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>4) Club Drugs</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> |
| <p>5) Cocaine</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>6) Heroin</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>7) Opioids</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>8) PCP</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> |
| <p>9) Hallucinogens</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>10) Inhalants</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | <p>11) Other</p> <p>DAYS ___/___</p> <p>WEEKS ___/___</p> <p>MONTHS ___/___</p> <p>YEARS ___/___</p> | |

INTENTIONALLY
BLANK

D4A. From now on, when I ask about your experiences with the medicines or drugs you have used, I will be using the term drugs.

Please look at Card 11. You might have noticed that the drugs are divided into categories on the card. From now on I will use the category name. So when I say (UNDERLINED DRUG CATEGORY), I am referring to (READ CIRCLED DRUGS IN THAT CATEGORY).
CONTINUE TO READ ALL BOXES IN WHICH THERE IS A CIRCLED DRUG.

D5. Did using (DRUG CATEGORY) cause you to have:

1. Problems with your family?
2. Problems with your friends?
3. Problems with people at work or school?
4. Did you get into physical fights while using (DRUG CATEGORY)?
5. Have you had legal problems because of your use of (DRUG CATEGORY)?

IF ALL CODED 1, GO TO D5 FOR NEXT DRUG CATEGORY. IF ANY CODED 5, CONTINUE.

A. Did you continue to use (DRUG CATEGORY) after you realized it was causing you to have any of those problems? IF NO, GO TO NEXT CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you continued to use (DRUG CATEGORY) after you realized (DRUG CATEGORY) was causing you to have any of those problems?

ONS: How old were you the first time (you continued to use (DRUG CATEGORY) after you realized (DRUG CATEGORY) was causing you to have any of those problems)?

GO TO D5 FOR NEXT DRUG CATEGORY.

| | | 1) Marijuana | | 2) Stimulants | | 3) Sedatives | | 4) Club Drugs | |
|------|--------------------------|------------------|------------|---------------|------------|--------------|------------|---------------|------------|
| | | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. | FAMILY | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. | FRIENDS | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. | PEOPLE AT WORK/SCHOOL | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. | FIGHTS | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. | LEGAL PROBLEMS | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| A. | | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| REC: | | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| | | MONTH | AGE | MONTH | AGE | MONTH | AGE | MONTH | AGE |
| ONS: | | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| | | AGE | AGE | AGE | AGE | AGE | AGE | AGE | AGE |
| | | 5) Cocaine | | 6) Heroin | | 7) Opioids | | 8) PCP | |
| | | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. | FAMILY | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. | FRIENDS | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. | PEOPLE AT WORK/SCHOOL | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. | FIGHTS | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. | LEGAL PROBLEMS | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| A. | | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| REC: | | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| | | MONTH | AGE | MONTH | AGE | MONTH | AGE | MONTH | AGE |
| ONS: | | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ |
| | | AGE | AGE | AGE | AGE | AGE | AGE | AGE | AGE |
| | | 9) Hallucinogens | | 10) Inhalants | | 11) Other | | | |
| | | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | | |
| 1. | FAMILY | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 2. | FRIENDS | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 3. | PEOPLE AT WORK/SCHOOL | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 4. | FIGHTS | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 5. | LEGAL PROBLEMS | 1 | 5 | 1 | 5 | 1 | 5 | | |
| A. | | 1 | 5 | 1 | 5 | 1 | 5 | | |
| REC: | | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | | |
| | | MONTH | AGE | MONTH | AGE | MONTH | AGE | | |
| ONS: | | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | ___/___ | | |
| | | AGE | AGE | AGE | AGE | AGE | AGE | | |

D6. Have there been times when you were under the influence of drugs when you could have gotten yourself or others hurt, or put yourself or others at risk? Some examples would include unprotected sex, driving, or operating equipment. NO ... GO TO D7 1
YES 5

A. Have there been times when you used (DRUG CATEGORY) in a situation when you could have gotten yourself or others hurt? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you used (DRUG CATEGORY) in a situation when you could have gotten yourself or others hurt?

ONS: How old were you the first time (you used (DRUG CATEGORY) in a situation when you could have gotten yourself or others hurt)?
GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|---|--|---|--|
| <p>1) Marijuana A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>2) Stimulants A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>3) Sedatives A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>4) Club Drugs A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> |
| <p>5) Cocaine A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>6) Heroin A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>7) Opioids A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>8) PCP A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> |
| <p>9) Hallucinogens A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>10) Inhalants A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>11) Other A: NO 1 YES 5</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | |

D7. Did your use of any of these drugs interfere with your responsibilities at home, at work, or at school? NO ... GO TO D8 1
 YES 5

A. Did your use of (DRUG CATEGORY) interfere with your responsibilities at home, work, or school at least several times? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time using (DRUG CATEGORY) interfered with your responsibilities?

ONS: How old were you the first time using (DRUG CATEGORY) interfered with your responsibilities? GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|--|---|--|---|
| <p>1) Marijuana A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>2) Stimulants A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>3) Sedatives A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>4) Club Drugs A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> |
| <p>5) Cocaine A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>6) Heroin A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>7) Opioids A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>8) PCP A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> |
| <p>9) Hallucinogens A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>10) Inhalants A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>11) Other A: NO 1 YES 5</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | |

- D8. Other than times when you were trying to quit or cut down, have you had a strong desire or craving for any of these drugs? NO GO TO D9 . 1
YES 5
- A. Did you have a strong desire or craving for (DRUG CATEGORY)? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.
- REC: When was the last time you had a strong desire or craving for (DRUG CATEGORY)?
- ONS: How old were you the first time (you had a strong desire or craving for (DRUG CATEGORY))? GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|--|---|--|---|
| <p>1) Marijuana</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>2) Stimulants</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>3) Sedatives</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>4) Club Drugs</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> |
| <p>5) Cocaine</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>6) Heroin</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>7) Opioids</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>8) PCP</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> |
| <p>9) Hallucinogens</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>10) Inhalants</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>11) Other</p> <p>A: NO 1 YES 5†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | |

IN ROW A ON TALLY CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.

D9. Have you often used more of a drug than you intended, or kept using a drug longer than you intended? NO . . . GO TO D10 1
 YES 5

A. Have you often used more (DRUG CATEGORY) or used (DRUG CATEGORY) longer than you intended? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you used more (DRUG CATEGORY) or used (DRUG CATEGORY) longer than you intended?

ONS: How old were you the first time (you used more (DRUG CATEGORY) or used it for longer than you intended)?

GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|---|--|---|--|
| <p>1) Marijuana A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>2) Stimulants A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>3) Sedatives A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>4) Club Drugs A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> |
| <p>5) Cocaine A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>6) Heroin A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>7) Opioids A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>8) PCP A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> |
| <p>9) Hallucinogens A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>10) Inhalants A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>11) Other A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | |

**IN ROW A ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.
 IN ROW B ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.**

D10. Has there ever been a period of time when you wanted to quit or cut down on any of these drugs or tried to quit or cut down but were unable to for at least a month? NO GO TO D11 1
 YES 5

A. Have you wanted to quit or cut down on (DRUG CATEGORY) or tried to quit or cut down but were unable to for at least a month? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you wanted to quit or cut down or tried to quit or cut down on (DRUG CATEGORY) but were unable to for at least a month?

ONS: How old were you the first time (you wanted to quit or cut down or tried to quit or cut down on (DRUG CATEGORY) but were unable to for at least a month)?
 GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|---|--|---|--|
| <p>1) Marijuana A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>2) Stimulants A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>3) Sedatives A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>4) Club Drugs A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> |
| <p>5) Cocaine A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>6) Heroin A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>7) Opioids A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>8) PCP A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> |
| <p>9) Hallucinogens A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>10) Inhalants A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | <p>11) Other A: NO 1 YES 5*† REC: ___/___ ___/___ MONTH AGE ONS: ___/___ AGE</p> | |

IN ROW C ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.
 IN ROW B ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.

D11. Has there ever been a period when you spent a lot of time using drugs, planning how you would get drugs, or recovering from their effects? NO ... GO TO D12 1
 YES 5

A. Have you ever spent a lot of time using, planning to get, or recovering from the effects of (DRUG CATEGORY)? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you spent a lot of time using, planning to get, or recovering from the effects of (DRUG CATEGORY)?

ONS: How old were you the first time (you spent a lot of time using, planning to get, or recovering from the effects of (DRUG CATEGORY))?
 GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|---|--|---|--|
| <p>1) Marijuana A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>2) Stimulants A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>3) Sedatives A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>4) Club Drugs A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> |
| <p>5) Cocaine A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>6) Heroin A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>7) Opioids A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>8) PCP A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> |
| <p>9) Hallucinogens A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>10) Inhalants A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>11) Other A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | |

IN ROW D ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.

IN ROW D ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.

- D12. Have you ever found that you had to use much more of any of these drugs than you used to in order to get the effect you wanted? NO ASK A 1
YES .. GO TO B 5
- A. Did you ever find that the same amount of any of these drugs had much less effect on you than it once did? NO .. GO TO D13 ... 1
YES 5
- B. Did you ever find (you had to use much more (DRUG CATEGORY) to get the effect you wanted/the same amount of (DRUG CATEGORY) had much less effect than before)? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.
- REC: Do you still find that (you have to use much more (DRUG CATEGORY) than you used to get the effect/the same amount of (DRUG CATEGORY) has much less effect)? IF YES, CODE MONTH=00. IF NO, ASK: When was the last time?
- ONS: How old were you the first time (you had to use much more (DRUG CATEGORY) to get the effect you wanted/the same amount of (DRUG CATEGORY) had much less effect than before)?
GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|---|--|---|--|
| <p>1) Marijuana B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>2) Stimulants B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>3) Sedatives B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>4) Club Drugs B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> |
| <p>5) Cocaine B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>6) Heroin B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>7) Opioids B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>8) PCP B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> |
| <p>9) Hallucinogens B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>10) Inhalants B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | <p>11) Other B: NO 1 YES 5*†</p> <p>REC: / / MONTH AGE</p> <p>ONS: / AGE</p> | |

IN ROW B ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.
IN ROW C ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.

D13. Did you give up or reduce any important activities to get or use any of these drugs, like getting together with friends or relatives, going to work or school, participating in sports or anything else? NO .. GO TO D14 ... 1
 YES 5

A. Did you give up or reduce any important activities to get or use (DRUG CATEGORY)? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you gave up or reduced any important activities to get or use (DRUG CATEGORY)?

ONS: How old were you the first time (you gave up or reduced important activities to get or use (DRUG CATEGORY))?

GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|--|---|--|---|
| <p>1) Marijuana</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>2) Stimulants</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>3) Sedatives</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>4) Club Drugs</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> |
| <p>5) Cocaine</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>6) Heroin</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>7) Opioids</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>8) PCP</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> |
| <p>9) Hallucinogens</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>10) Inhalants</p> <p>A: NO 1 YES 5*†</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | <p>11) Other</p> <p>A: NO 1 YES</p> <p>REC: / / / / MONTH AGE</p> <p>ONS: / / AGE</p> | |

**IN ROW E ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.
 IN ROW D ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.**

D14. People have told us about a number of withdrawal symptoms they have experienced within the first few hours or days of not using drugs.

A. During the first few hours or days of not using (DRUG) did you (READ EACH AND CODE):
IF ALL CODED 1, GO TO NEXT DRUG CATEGORY. IF ANY CODED 5, CONTINUE.

REC: When was the last time you had any of these symptoms during the first few hours or days of not using (DRUG)?

ONS: How old were you the first time (you had any of these symptoms during the first few hours or days of not using (DRUG))?
GO TO A FOR NEXT DRUG CATEGORY.

| A: | 1) Marijuana | | 2) Stimulants | | 3) Sedatives | | 4) Club Drugs | |
|--|---|--|---|--|---|--|---|--|
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. Feel depressed? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. Feel anxious, restless, or irritable? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. Have trouble concentrating? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. Feel tired, sleepy or weak? . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. Have trouble sleeping? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 6. Tremble or twitch? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 7. Sweat or have fever? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 8. Feel nauseated or vomit? . . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 9. Have diarrhea or a stomachache? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 10. Have a change in appetite? . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 11. See, hear or feel things that weren't there? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 12. Have runny eyes or nose? . . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 13. Have seizures? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 14. Have muscle pains? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 15. Yawn a lot? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 16. Have a fast heartbeat? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 17. Have vivid, unpleasant dreams? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 18. Have a headache? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 19. Crave (DRUG)? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| | REC: <u> </u> / <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> / <u> </u> AGE |
| | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE |

| | | 5) Cocaine | | 6) Heroin | | 7) Opioids | | 8) PCP | |
|-----|--|---|----------------------------------|---|----------------------------------|---|----------------------------------|---|----------------------------------|
| A: | | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. | Feel depressed? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. | Feel anxious, restless, or irritable? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. | Have trouble concentrating? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. | Feel tired, sleepy or weak? . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. | Have trouble sleeping? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 6. | Tremble or twitch? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 7. | Sweat or have fever? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 8. | Feel nauseated or vomit? . . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 9. | Have diarrhea or a stomachache? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 10. | Have a change in appetite? . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 11. | See, hear or feel things that weren't there? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 12. | Have runny eyes or nose? . . . | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 13. | Have seizures? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 14. | Have muscle pains? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 15. | Yawn a lot? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 16. | Have a fast heartbeat? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 17. | Have vivid, unpleasant dreams? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 18. | Have a headache? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 19. | Crave (DRUG)? | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| | | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE |
| | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | |
| A: | | 9) Hallucinogens | | 10) Inhalants | | 11) Other | | | |
| | | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | | |
| 1. | Feel depressed? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 2. | Feel anxious, restless, or irritable? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 3. | Have trouble concentrating? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 4. | Feel tired, sleepy or weak? . . | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 5. | Have trouble sleeping? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 6. | Tremble or twitch? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 7. | Sweat or have fever? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 8. | Feel nauseated or vomit? . . . | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 9. | Have diarrhea or a stomachache? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 10. | Have a change in appetite? . . | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 11. | See, hear or feel things that weren't there? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 12. | Have runny eyes or nose? . . . | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 13. | Have seizures? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 14. | Have muscle pains? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 15. | Yawn a lot? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 16. | Have a fast heartbeat? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 17. | Have vivid, unpleasant dreams? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 18. | Have a headache? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 19. | Crave (DRUG)? | 1 | 5 | 1 | 5 | 1 | 5 | | |
| | | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | | |
| | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | | |

**IN ROW F ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY HAVING ANY 5 CODED.
IN ROW E ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY HAVING ANY 5 CODED.**

D15. Did you ever use any of these drugs to avoid or get rid of withdrawal symptoms? NO...GO TO D16 . . 1
YES 5

A. Have you ever used (DRUG CATEGORY) to avoid (or get rid of) withdrawal symptoms caused by (DRUG CATEGORY)? IF NO, CODE 1 AND GO TO NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.

REC: When was the last time you used (DRUG CATEGORY) to avoid (or get rid of) withdrawal symptoms from (DRUG CATEGORY)?

ONS: How old were you the first time (you used (DRUG CATEGORY) to avoid (or get rid of) withdrawal symptoms from (DRUG CATEGORY))?
GO TO A FOR NEXT DRUG CATEGORY.

| | | | |
|--|---|--|---|
| <p>1) Marijuana A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>2) Stimulants A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>3) Sedatives A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>4) Club Drugs A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> |
| <p>5) Cocaine A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>6) Heroin A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>7) Opioids A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>8) PCP A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> |
| <p>9) Hallucinogens A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>10) Inhalants A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | <p>11) Other A: NO 1 YES 5*†</p> <p>REC: ___/___ ___/___ MONTH AGE</p> <p>ONS: ___/___ AGE</p> | |

**IN ROW F ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.
IN ROW E ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.**

**INTENTIONALLY
BLANK**

- D16. A. (Other than withdrawal symptoms), did using (DRUG CATEGORY) cause you any physical health problems like (READ EACH AND CODE): IF ALL CODED 1, GO TO NEXT DRUG CATEGORY. IF ANY CODED 5, ASK:**
- B. Did you continue to use (DRUG CATEGORY) after you realized it was causing any of these physical health problems? IF NO, GO TO A FOR NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.**
- REC: When was the last time you continued to use (DRUG CATEGORY) after you realized it was causing any of these physical health problems?**
- ONS: How old were you the first time (you continued to use (DRUG CATEGORY) after you realized it was causing any of these physical health problems)?
GO TO NEXT DRUG CATEGORY.**

| A: | 1) Marijuana | | 2) Stimulants | | 3) Sedatives | | 4) Club Drugs | |
|---|---|------------|---|------------|---|------------|---|------------|
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. Unintended weight loss or gain | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. A seizure | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. A persistent cough | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. Eye problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. An injury or burn | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 6. Heart pounding | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 7. Sexual difficulties | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 8. An overdose | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 9. A sore throat or sinus problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 10. Trembling, twitching, or numbness | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 11. Headaches or dizziness | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 12. Stomach problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 13. Kidney problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| B. | 1 | 5*† | 1 | 5*† | 1 | 5*† | 1 | 5*† |
| | REC: <u> </u> / <u> </u> MONTH AGE | | REC: <u> </u> / <u> </u> MONTH AGE | | REC: <u> </u> / <u> </u> MONTH AGE | | REC: <u> </u> / <u> </u> MONTH AGE | |
| | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | |

| A: | 5) Cocaine | | 6) Heroin | | 7) Opioids | | 8) PCP | |
|---|------------|------------|-----------|------------|------------|------------|-----------|------------|
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. Unintended weight loss or gain | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. A seizure | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. A persistent cough | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. Eye problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |

| | | | | | | | | |
|--|-----------------------------------|----------------------------|-----------------------------------|----------------------------|-----------------------------------|----------------------------|-----------------------------------|----------------------------|
| 5. An injury or burn | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 6. Heart pounding | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 7. Sexual difficulties | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 8. An overdose | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 9. A sore throat or sinus problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 10. Trembling, twitching, or numbness .. | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 11. Headaches or dizziness | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 12. Stomach problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 13. Kidney problems | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| B. | 1 | 5*† | 1 | 5*† | 1 | 5*† | 1 | 5*† |
| | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ |
| | ONS: $\frac{\quad}{\text{AGE}}$ | | ONS: $\frac{\quad}{\text{AGE}}$ | | ONS: $\frac{\quad}{\text{AGE}}$ | | ONS: $\frac{\quad}{\text{AGE}}$ | |
| A: | 9) Hallucinogens | | 10) Inhalants | | 11) Other | | | |
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | | |
| 1. Unintended weight loss or gain | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 2. A seizure | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 3. A persistent cough | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 4. Eye problems | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 5. An injury or burn | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 6. Heart pounding | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 7. Sexual difficulties | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 8. An overdose | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 9. A sore throat or sinus problems | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 10. Trembling, twitching, or numbness .. | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 11. Headaches or dizziness | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 12. Stomach problems | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 13. Kidney problems | 1 | 5 | 1 | 5 | 1 | 5 | | |
| B. | 1 | 5*† | 1 | 5*† | 1 | 5*† | | |
| | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ | REC: $\frac{\quad}{\text{MONTH}}$ | $\frac{\quad}{\text{AGE}}$ | | |
| | ONS: $\frac{\quad}{\text{AGE}}$ | | ONS: $\frac{\quad}{\text{AGE}}$ | | ONS: $\frac{\quad}{\text{AGE}}$ | | | |

IN ROW G ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.

IN ROW F ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5 †.

- D17. A. (Other than withdrawal symptoms) did using (DRUG CATEGORY) cause you to have any emotional or psychological problems like (READ EACH AND CODE)? IF ALL CODED 1, GO TO THE NEXT DRUG CATEGORY. IF ANY CODED 5, ASK:**
- B. Did you continue to use (DRUG CATEGORY) after you realized it was causing any of these emotional or psychological problems? IF NO, GO TO A FOR NEXT DRUG CATEGORY. IF YES, CODE 5 AND CONTINUE.**

REC: When was the last time you continued to use (DRUG CATEGORY) after you realized it was causing any of these emotional or psychological problems?

ONS: How old were you the first time (you continued to use (DRUG CATEGORY) after you realized it was causing any of these emotional or psychological problems)?

GO TO NEXT DRUG CATEGORY.

| A: | 1) Marijuana | | 2) Stimulants | | 3) Sedatives | | 4) Club Drugs | |
|---|--|------------|--|------------|--|------------|--|------------|
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. feeling depressed or empty | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. being paranoid or suspicious | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. feeling confused | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. feeling anxious or tense | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. being irritable or aggressive | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 6. feeling keyed up or overactive | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 7. seeing, hearing, smelling or feeling things that weren't there | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 8. laughing or crying for no reason | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 9. being jumpy or easily startled | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 10. feeling overconfident or fearless | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| B. | 1 | 5*† | 1 | 5*† | 1 | 5*† | 1 | 5*† |
| | REC: <u> </u> / <u> </u> MONTH AGE | | REC: <u> </u> / <u> </u> MONTH AGE | | REC: <u> </u> / <u> </u> MONTH AGE | | REC: <u> </u> / <u> </u> MONTH AGE | |
| | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | | ONS: <u> </u> / <u> </u> AGE | |

| A: | 5) Cocaine | | 6) Heroin | | 7) Opioids | | 8) PCP | |
|--|---|----------------------------------|---|----------------------------------|---|----------------------------------|---|----------------------------------|
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> |
| 1. feeling depressed or empty | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 2. being paranoid or suspicious | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 3. feeling confused | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 4. feeling anxious or tense | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 5. being irritable or aggressive | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 6. feeling keyed up or overactive | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 7. seeing, hearing, smelling, or feeling things that weren't there | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 8. laughing or crying for no reason | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 9. being jumpy or easily startled | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| 10. feeling overconfident or fearless | 1 | 5 | 1 | 5 | 1 | 5 | 1 | 5 |
| B. | 1 | 5*† | 1 | 5*† | 1 | 5*† | 1 | 5*† |
| | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE |
| | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE |
| A: | 9) Hallucinogens | | 10) Inhalants | | 11) Other | | | |
| | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> | <u>YES</u> | | |
| 1. feeling depressed or empty | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 2. being paranoid or suspicious | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 3. feeling confused | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 4. feeling anxious or tense | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 5. being irritable or aggressive | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 6. feeling keyed up or overactive | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 7. seeing, hearing, smelling, or feeling things that weren't there | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 8. laughing or crying for no reason | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 9. being jumpy or easily startled | 1 | 5 | 1 | 5 | 1 | 5 | | |
| 10. feeling overconfident or fearless | 1 | 5 | 1 | 5 | 1 | 5 | | |
| B. | 1 | 5*† | 1 | 5*† | 1 | 5*† | | |
| | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AG | REC: <u> </u> / <u> </u> MONTH | <u> </u> / <u> </u> AGE | | |
| | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | ONS: <u> </u> / <u> </u> AGE | <u> </u> / <u> </u> AGE | | |

**IN ROW G ON CARD 15, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5*.
IN ROW F ON CARD 16, CIRCLE THE NUMBER OF EACH DRUG CATEGORY CODED 5†.**

| | | |
|------|--|--------------------------------------|
| D18. | In the past 12 months, did you seek help from a doctor or other health professional for any problems related to your drug use? | NO 1 YES . GO TO D19 5 |
| A. | Have you <u>ever</u> talked to a doctor or other health professional about any problems from using drugs? | NO 1 YES 5 |

| | | |
|------|---|---|
| D19. | From the time you first started using any drug on this card (REFER TO CARD 11), up to now, what is the longest period of time you've been completely off every circled drug on this card? IF NEVER FOR AN ENTIRE DAY, CODE 00 DAYS AND GO TO C. | DAYS ___/___ WEEKS ___/___ MONTHS ___/___ YEARS ___/___ |
| A. | Did you begin using drugs again after that period? | NO 1 YES 5 |
| B. | Did you drink alcohol at all while you were off drugs? | NO 1 YES 5 |

C. IF D10 = YES, CONTINUE. OTHERS GO TO D20.
Here is a list of reasons people want to quit or try to quit using drugs. HAND CARD 14 TO R. Which one of these reasons made you want to quit or try to quit the most recent time?

- 1 = A doctor or nurse advised you to
- 2 = Your family or friends asked you to
- 3 = It cost too much
- 4 = You got tired of it
- 5 = Using drugs is bad for you
- 6 = It caused unpleasant side effects
- 7 = Pregnancy
- 8 = Legal problems
- 9 = OTHER (SPECIFY) _____

_____ REASON CODE

IF R SAYS NONE ON THE LIST, ASK:
What did make you want to quit or try to quit?
RECORD RESPONSE IN 9, AND GO TO D20.

| | | |
|------|---|--|
| D20. | DOES CARD 15 HAVE 3 OR MORE IDENTICAL NUMBERS CIRCLED IN ANY DRUG COLUMN? | NO. . . . (GO TO D22) . 1 YES 5 |
|------|---|--|

INTENTIONALLY
BLANK

D21. HAND CARD 15 TO R.

FOR FIRST DRUG COLUMN CONTAINING 3 OR MORE IDENTICAL NUMBERS CIRCLED ON CARD 15, READ: You mentioned the following experiences related to your use of (DRUG CATEGORY): you (READ ALL SYMPTOMS WITH CIRCLED NUMBERS IN THAT COLUMN OF CARD 15). Did at least 3 of these experiences from using (DRUG CATEGORY) ever occur together within the same 12-month period?

REC: How old were you the last time at least 3 of these experiences from using (DRUG CATEGORY) occurred together within the same 12-month period?

ONS: How old were you the first time (at least 3 of these experiences from using (DRUG CATEGORY) occurred together within the same 12-month period)? IF ONS AGE WITHIN 2 YEARS OF REC AGE, GO TO D. OTHERS CONTINUE:

REM: You said you were (ONS AGE) when you first had 3 or more of these experiences from using (DRUG CATEGORY) together within the same 12-month period. You were (REC AGE) the last time 3 or more of these experiences from using (DRUG CATEGORY) occurred together within the same 12-month period. Between these ages, have you had at least a year when none of these experiences from using (DRUG CATEGORY) occurred at all?

| 1) Marijuana | | 2) Stimulants | | 3) Sedatives | | 4) Club Drugs | |
|--------------|---------|---------------|---------|--------------|---------|---------------|---------|
| NO | GO TO D | NO | GO TO D | NO | GO TO D | NO | GO TO D |
| | | | | | | | |
| 1 | | 1 | | 1 | | 1 | |
| YES | | YES | | YES | | YES | |
| | | | | | | | |
| 5 | | 5 | | 5 | | 5 | |
| REC AGE: | ___/___ | REC AGE: | ___/___ | REC AGE: | ___/___ | REC AGE: | ___/___ |
| ONS AGE: | ___/___ | ONS AGE: | ___/___ | ONS AGE: | ___/___ | ONS AGE: | ___/___ |
| REM: NO | GO TO D | REM: NO | GO TO D | REM: NO | GO TO D | REM: NO | GO TO D |
| | | | | | | | |
| 1 | | 1 | | 1 | | 1 | |
| YES | | YES | | YES | | YES | |
| | | | | | | | |
| 5 | | 5 | | 5 | | 5 | |
| A: | ___/___ | A: | ___/___ | A: | ___/___ | A: | ___/___ |
| FROM AGE | TO AGE | FROM AGE | TO AGE | FROM AGE | TO AGE | FROM AGE | TO AGE |
| B: | ___/___ | B: | ___/___ | B: | ___/___ | B: | ___/___ |
| FROM AGE | TO AGE | FROM AGE | TO AGE | FROM AGE | TO AGE | FROM AGE | TO AGE |
| C: | NO | C: | NO | C: | NO | C: | NO |
| | | | | | | | |
| 1 | | 1 | | 1 | | 1 | |
| YES | | YES | | YES | | YES | |
| | | | | | | | |
| 5 | | 5 | | 5 | | 5 | |

| | | | |
|---|--|---|---|
| <p style="text-align: center;">5) Cocaine</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> | <p style="text-align: center;">6) Heroin</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> | <p style="text-align: center;">7) Opioids</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> | <p style="text-align: center;">8) PCP</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> |
| <p style="text-align: center;">9) Hallucinogens</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> | <p style="text-align: center;">10) Inhalants</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> | <p style="text-align: center;">12) Other</p> <p>NO GO TO D 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> <p>REM: NO ... GO TO D ... 1 YES 5</p> <p>A: ___/___ ___/___ FROM AGE TO AGE</p> <p>B: ___/___ ___/___ FROM AGE TO AGE</p> <p>C: NO 1 YES 5</p> | |

D22. DOES CARD 16 HAVE 3 OR MORE IDENTICAL NUMBERS CIRCLED IN ANY DRUG COLUMN? NO . . . GO TO SECTION E . . . 1
YES 5

D23. HAND CARD 16 TO R.
FOR FIRST DRUG COLUMN CONTAINING 3 OR MORE IDENTICAL NUMBERS CIRCLED ON CARD 16,
READ: You mentioned the following experiences related to using (DRUG CATEGORY): you (READ ALL SYMPTOMS WITH CIRCLED NUMBERS IN THAT COLUMN OF CARD 16). Did at least 3 of these experiences from using (DRUG CATEGORY) ever occur together several times within a 12-month period?

A. Did at least 3 of these experiences from using (DRUG CATEGORY) ever occur together for at least a month?

REC: How old were you the last time at least 3 of these experiences from using (DRUG CATEGORY) (occurred together several times within a 12-month period/occurred together for at least a month)?

ONS: How old were you the first time at least 3 of these experiences from using (DRUG CATEGORY) (occurred together several times within a 12-month period/occurred together for at least a month)?

B. REPEAT D23 FOR NEXT COLUMN WITH 3 OR MORE IDENTICAL NUMBERS CIRCLED ON CARD 16. IF NO MORE COLUMNS HAVE 3+ IDENTICAL NUMBERS CIRCLED, GO TO SECTION E.

| 1) Marijuana | 2) Stimulants | 3) Sedatives | 4) Club Drugs |
|---|---|---|---|
| NO 1 YES GO TO REC 5 | NO 1 YES GO TO REC 5 | NO 1 YES GO TO REC 5 | NO 1 YES GO TO REC 5 |
| A. NO ... GO TO B 1 YES 5 | A. NO ... GO TO B 1 YES 5 | A. NO ... GO TO B 1 YES 5 | A. NO ... GO TO B 1 YES 5 |
| REC AGE: ___/___ | REC AGE: ___/___ | REC AGE: ___/___ | REC AGE: ___/___ |
| ONS AGE: ___/___ | ONS AGE: ___/___ | ONS AGE: ___/___ | ONS AGE: ___/___ |

| | | | |
|--|---|---|--|
| <p style="text-align: center;">5) Cocaine</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO ... GO TO B 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> | <p style="text-align: center;">6) Heroin</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO . GO TO B..... 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> | <p style="text-align: center;">7)Opioids</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO GO TO B .. 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> | <p style="text-align: center;">8) PCP</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO GO TO B .. 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> |
| <p style="text-align: center;">9) Hallucinogens</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO GO TO B .. 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> | <p style="text-align: center;">10) Inhalants</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO GO TO B 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> | <p style="text-align: center;">11) Other</p> <p>NO 1 YES GO TO REC 5</p> <p>A. NO GO TO B .. 1 YES 5</p> <p>REC AGE: ___/___</p> <p>ONS AGE: ___/___</p> | |

SECTION E

E1. Now I'd like to ask you some questions about your use of caffeine. Caffeine can be taken in a variety of ways, including coffee, tea, soda, pain pills, cold remedies, anti-drowsiness pills, weight loss pills, and chocolate. In this questionnaire, we're only interested in your consumption of caffeine in beverages like coffee, tea, espresso, colas, Mountain Dew, or any other drinks with caffeine.

A. When was the last time you had a drink containing caffeine? Was it:

- in the past 24 hours? GO TO E2 1
- not in the past 24 hours, but in the past 7 days? GO TO E2 2
- not in the past 7 days, but in the past 30 days? GO TO E3A 3
- more than 30 days ago, but in the past 12 months? GO TO B 4
- more than 12 months ago? GO TO C 5
- or never? GO TO SECTION F 6

B. What month was that?

____/____
MONTH

GO TO E3A

C. How old were you then?

____/____
AGE

GO TO E4A

E2. In the past 7 days, on the average, how many drinks containing caffeine have you had in one 24 hour period?

____ _
DRINKS

E3. Was your use of caffeinated beverages in the past 7 days pretty much like your weekly use of caffeine in the past 12 months? NO 1
YES . . . GO TO E4 5

A. During weeks when you were drinking caffeinated beverages in the past 12 months, how many drinks with caffeine, on the average, would you usually have in one 24 hour period?

____ _
DRINKS

B. During the past 12 months how many days a week did you have (# DRINKS IN A) caffeinated beverages in a 24 hour period? IF LESS THAN 1 TIME A WEEK CODE 00.

| | | |
|-----|--|---|
| E4. | Has there ever been a time in your life when you drank more caffeinated beverages than you did in the past 12 months? | NO. . . . GO TO E5 1 YES 5 |
| A. | Think about the time when you were drinking caffeinated beverages the most. How old were you when that period started? | ____/____ AGE |
| B. | How many caffeinated beverages would you usually have in one 24 hour period during that time? | _____ # DRINKS |
| C. | How long did that period last? ENTER DURATION AND CIRCLE UNIT. | ____/____ DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 |

| | | |
|-----|--|------------------|
| E5. | At what age did you begin to drink caffeinated beverages regularly -- that is, at least one caffeinated beverage 3 or 4 days a week for a month? IF NEVER DRANK THAT MUCH, CODE 00 AND GO TO F1. | ____/____ AGE |
|-----|--|------------------|

| | | |
|-----|---|---|
| E6. | From the time you first had a caffeinated beverage up to now, what is the longest period of time you have gone without any at all? ENTER DURATION AND CIRCLE UNIT. IF NEVER FOR AN ENTIRE DAY, ENTER 00 AND CIRCLE DAYS. | ____/____ DAYS 1 WEEKS 2 MONTHS 3 YEARS 4 |
|-----|---|---|

IF CURRENT MONTH, CODE MONTH = 00, OR IF **NOT** IN PAST 12 MONTHS,
ENTER AGE. OTHERS CODE ACTUAL MONTH.

| | | |
|------|---|--|
| E7. | Have you frequently made special trips to the store to get a caffeinated beverage, or planned ahead to have caffeine drinks with you so you wouldn't run out? | NO. . . . GO TO E8 1 YES 5*† |
| REC: | When was the last time you made special trips or planned ahead so you wouldn't run out of caffeinated drinks? | ____/____ MONTH AGE |
| ONS: | How old were you the first time? | ____/____ AGE |
| E8. | After you had been drinking caffeinated beverages for a while, did you find that you needed to drink more of them than you used to to get the same effect? | NO 1 YES. . . . GO TO ONS . 5*† |
| A. | After you had been drinking caffeinated beverages for a while, did you find that the usual amount you drank had much less effect on you? | NO. . . . GO TO E9 1 YES 5*† |
| ONS: | How old were you the first time you (found you had to drink more caffeinated beverages than you used to/found that caffeine had much less effect on you)? | ____/____ AGE |
| REC: | Do you still find that (you need to drink more caffeinated beverages than you used to/caffeine has much less effect on you)? IF YES, CODE MONTH = 00. IF NO, ASK: When was the last time? | ____/____ MONTH AGE |
| E9. | Have you often had more caffeinated beverages than you intended? | NO. . . . GO TO E10 1 YES 5*† |
| REC: | When was the last time that happened? | ____/____ MONTH AGE |
| ONS: | How old were you the first time? | ____/____ AGE |
| E10. | Has there ever been a period of time when you wanted to quit or cut down on your use of caffeinated beverages? | NO. . . . GO TO E11 1 YES 5*† |
| REC: | When was the last time you wanted to quit or cut down? | ____/____ MONTH AGE |
| ONS: | How old were you the first time? | ____/____ AGE |
| E11. | Have you ever tried to quit or cut down on your use of caffeinated beverages? | NO. . . . GO TO E13 1 YES 5 |

JAN = 01, FEB = 02, MAR = 03, APR = 04, MAY = 05, JUN = 06, JUL = 07, AUG = 08, SEP = 09, OCT = 10, NOV = 11, DEC = 12.

Refused = 97, Don't Know = 98

| | | | |
|------|---|--------------------|------------------|
| E12. | When you decided to quit or cut down on drinking caffeinated beverages, were you always able to do so for at least one month? | NO | 1 |
| | | YES. | GO TO E13 5 |
| A. | Was there more than one time when you couldn't quit or cut down drinking caffeine for at least one month? | NO | 1 |
| | | YES | 5*† |
| REC: | When was the last time (you couldn't quit or cut down for at least a month)? | ____/____ MONTH | ____/____ AGE |
| ONS: | How old were you the first time (you couldn't quit or cut down for at least a month)? | | ____/____ AGE |

E13. IF E10 OR E11 = YES, CONTINUE. OTHERS GO TO E14. Here is a list of reasons people want to quit or try to quit drinking beverages with caffeine. HAND CARD 17 TO R. Which one of these reasons made you want to quit or try to quit the most recent time?

REASON
CODE

1 = A doctor or nurse advised you to

2 = Your family or friends asked you to

3 = It cost too much

4 = You got tired of it

5 = It's bad for you

6 = It caused unpleasant side effects

7 = Pregnancy

8 = OTHER (SPECIFY)_____

IF R SAYS NONE APPLY, ASK:
What did make you want to quit or try to quit?
RECORD RESPONSE IN 8, AND GO TO E14.

IF CURRENT MONTH, CODE MONTH = 00, OR IF NOT IN PAST 12 MONTHS,
ENTER AGE. OTHERS CODE ACTUAL MONTH.

| | | | | |
|--|---|--------------------|---------------------------------|-------------------|
| E14. People who drink caffeinated beverages every day for a period of time can have withdrawal symptoms if they try to quit or cut down, if they run out, or if they are in a situation where none is available. Within 24-48 hours of reducing or going without caffeinated beverages, or switching to decaffeinated drinks . . . | | | <u>NO</u> | <u>YES</u> |
| 1) | did you have a headache? | 1 | 5 | |
| 2) | did you feel very tired or drowsy? | 1 | 5 | |
| 3) | did you feel very anxious or depressed? | 1 | 5 | |
| 4) | . . .feel nauseated or vomit? | 1 | 5 | |
| 5) | . . . have trouble concentrating? | 1 | 5 | |
| 6) | . . . did you crave caffeine? | 1 | 5 | |
| 7) | . . . did you have an increased appetite? | 1 | 5 | |
| 8) | . . . have sleep problems? | 1 | 5 | |
| A. ARE THERE ONE OR MORE ITEMS CODED YES IN 1-8? | | NO | 1 | YES 5*† |
| E15. Have you ever used a caffeine product or had a caffeinated beverage to avoid (or get rid of) withdrawal symptoms? | | | NO | 1 |
| | | | YES | 5*† |
| E16. ARE E14A <u>AND</u> E15 BOTH CODED NO? | | | NO | 1 |
| | | | YES.GO TO E17 | 5 |
| REC: When was the last time you (had withdrawal symptoms when you went without caffeine/(or) used caffeine to avoid or get rid of withdrawal symptoms)? | | ____/____ MONTH | | ____/____ AGE |
| ONS: How old were you the first time? | | | | ____/____ AGE |

| | | | |
|------|--|-----------|------------|
| E17. | Other than withdrawal symptoms, did caffeinated beverages ever cause you to have physical problems like: | <u>NO</u> | <u>YES</u> |
| 1) | trouble falling asleep or staying asleep? | 1 | 5 |
| 2) | flushed face? | 1 | 5 |
| 3) | frequent urination? | 1 | 5 |
| 4) | stomach problems? | 1 | 5 |
| 5) | muscle twitching or weakness? | 1 | 5 |
| 6) | fast or irregular heartbeat or chest pain? | 1 | 5 |
| 7) | chills or sweating | 1 | 5 |
| 8) | weight loss? | 1 | 5 |

IF 1-8 ALL CODED NO, GO TO E18.

| | | | |
|----|--|-----------|-----|
| A. | Did you continue using caffeinated beverages after realizing they were causing any of these physical problems? | NO | 1 |
| | | YES | 5*† |

| | | | |
|------|---|----------------------|-----|
| E18. | Did you continue to drink caffeinated beverages after you found out you had a medical condition or health problem that could be made worse by caffeine? | NO....GO TO E19 | 1 |
| | | YES | 5*† |

A. What was the condition or health problem?

CONDITION: _____

| | | | |
|------|--|-----------|------------|
| E19. | Other than withdrawal symptoms, did caffeinated beverages ever cause you to have emotional or psychological problems, such as: | <u>NO</u> | <u>YES</u> |
| 1) | feeling very anxious, jittery or nervous? | 1 | 5 |
| 2) | feeling paranoid? | 1 | 5 |
| 3) | feeling irritable or angry? | 1 | 5 |

IF 1-3 ALL CODED NO, GO TO E20. OTHERS ASK:

| | | | |
|----|--|-----------|-----|
| A. | Did you continue to drink caffeinated beverages after you realized they were causing any of these emotional or psychological problems? | NO | 1 |
| | | YES | 5*† |

IF CURRENT MONTH, CODE MONTH = 00, IF NOT IN PAST 12 MONTHS,
ENTER AGE. OTHERS CODE ACTUAL MONTH.

SECTION E

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| | | | |
|------|---|--------------------|------------------|
| E20. | IF E17A, E18, <u>AND</u> E19A ALL CODED NO, GO TO E21. OTHERS CONTINUE. | | |
| | REC: When was the last time you continued to use caffeine after realizing it was related to a (physical/emotional) problem? | ____/____ MONTH | ____/____ AGE |
| | ONS: How old were you the first time? | | ____/____ AGE |

| | | | |
|------|--|-----------|---|
| E21. | Have you ever talked to a doctor or health professional about any problems from your use of caffeinated beverages? | NO | 1 |
| | | YES | 5 |

| | | | |
|------|---|-----------------------|------------------|
| E22. | Other than times when you were trying to quit or cut down, have you often had a strong desire or craving for caffeinated beverages? | NO....GO TO E23 | 1 |
| | | YES | 5† |
| | REC: When was the last time? | ____/____ MONTH | ____/____ AGE |
| | ONS: How old were you the first time? | | ____/____ AGE |

| | | | |
|------|---|-----------------------|------------------|
| E23. | Have you sometimes avoided doing things or going places because there wouldn't be any caffeine available? | NO....GO TO E24 | 1 |
| | | YES | 5*† |
| | REC: When was the last time? | ____/____ MONTH | ____/____ AGE |
| | ONS: How old were you the first time? | | ____/____ AGE |

| | | | |
|------|--|-----------------------|------------------|
| E24. | Has there ever been a period in your life when you felt you needed caffeinated beverages to help you function – that is, you felt you could not do your work well unless you had had a caffeinated beverage? | NO....GO TO E25 | 1 |
| | | YES | 5 |
| | REC: When was the last time? | ____/____ MONTH | ____/____ AGE |
| | ONS: How old were you the first time? | | ____/____ AGE |

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Refused = 97, Don't Know = 98

E25. ON CARD 18, CIRCLE THE ITEMS CODED 5* IN E7-E23 AND CHECK THE SMALL BOXES WHERE THERE ARE CIRCLED ITEMS. ARE THERE 3 OR MORE SMALL BOXES CHECKED?

NO. . . . GO TO E28 1
 YES 5

E26. HAND CARD 18 TO R.
 You mentioned that you (LIST CIRCLED ITEMS ON CARD 18). For the purpose of this interview, each box on this card represents one experience, even when more than one item is circled in a box. You have reported (# OF BOXES CHECKED) experiences.

Did at least three of these (# OF BOXES CHECKED) experiences ever occur together within the same 12-month period?

NO. . . . GO TO E28 1
 YES 5

REC: How old were you the last time at least three of these (# OF BOXES CHECKED) experiences occurred together within the same 12-month period?

____/____
 AGE

ONS: How old were you the first time?

____/____
 AGE

IF CURRENT MONTH, CODE MONTH = 00, OR IF **NOT** IN PAST 12 MONTHS,
 ENTER AGE. OTHERS CODE ACTUAL MONTH.

-
- E27. IF ONS AGE WITHIN 2 YEARS OF REC AGE IN E26, GO TO E28. OTHERS ASK:
- REM: You said you were (ONS AGE) when you first had three or more of these experiences together within the same 12-month period from using caffeinated beverages. You were (REC AGE) the last time three or more of these experiences occurred together within the same 12-month period. Have you had a full year or more when none of these experiences occurred at all?
- NO. . . . GO TO E28 1
YES 5
- A. Between what ages did you have none of these experiences? ____/____ ____/____
FROM AGE TO AGE
- B. Any other ages?
IF "NO", CODE 00 IN "FROM AGE." ____/____ ____/____
FROM AGE TO AGE
- C. DID R MENTION MORE THAN 2 REMISSIONS? NO 1
YES 5
-

- E28. ON CARD 19, CIRCLE THE ITEMS CODED 5+ IN E7-E23 AND CHECK THE SMALL BOXES WHERE THERE ARE CIRCLED ITEMS. ARE THERE 3 OR MORE SMALL BOXES CHECKED?
- NO. . . . GO TO F1 1
YES 5
-

- E29. HAND CARD 19 TO R.
You mentioned that you (LIST CIRCLED ITEMS ON CARD 19). (This question is somewhat similar to the previous one.) For the purpose of this interview, each box on this card represents one experience, even when more than one item is circled in a box. You have reported (# OF BOXES CHECKED) experiences.
- Did at least three of these (# OF BOXES CHECKED) experiences ever occur together several times within a 12-month period? NO. . . . GO TO A 1
YES. . . GO TO REC 5
- A. Did at least three of these (# OF BOXES CHECKED) experiences ever occur together for at least a month? NO. . . . GO TO F1 1
YES 5
- REC: How old were you the last time (at least three of these experiences occurred together several times within a 12-month period/at least three of these experiences occurred together for at least a month)? ____/____
AGE
- ONS: How old were you the first time? ____/____
AGE
-

SECTION F

F1. That's all the questions I have for you. Thank you very much for your time and effort.

NOTE: THIS SECTION MUST BE COMPLETED, BUT NOT IN THE PRESENCE OF THE RESPONDENT.

F2. WAS THE INTERVIEW GIVEN IN MORE THAN ONE SESSION? NO ... GO TO F3 1
YES 5

A. HOW MANY DAYS CAME BETWEEN THE FIRST AND LAST SESSION? _____

B. WHAT WAS THE REASON FOR THE INTERRUPTION? INT. EMERGENCY 1
R EMERGENCY 2
R TIRED, BORED 3
R ANGRY/UPSET ABOUT QUESTIONS 4

F3. DID R APPEAR DRUNK OR HIGH ON DRUGS DURING THE INTERVIEW (SPEECH SLURRED, STAGGERED OR STUMBLER WHEN WALKING, BREATH SMELLED OF ALCOHOL)? NO 1
YES 5

| F4. RECORD ANY DIFFICULTIES IN CONDUCTING THE INTERVIEW: | NO | YES |
|--|----|-----|
| 1. LACK OF PRIVACY | 1 | 5 |
| 2. R UPSET | 1 | 5 |
| 3. R UNCOOPERATIVE | 1 | 5 |
| 4. R RESPONDED VERY SLOWLY | 1 | 5 |
| 5. R VERY TALKATIVE | 1 | 5 |
| 6. SERIOUS TIME CONSTRAINTS | 1 | 5 |
| 7. R OFTEN MISUNDERSTOOD QUESTIONS | 1 | 5 |
| 8. OTHER: _____ | 1 | 5 |

F5. WERE THERE ANY QUESTIONS THAT SEEMED UNCLEAR OR CONFUSING TO R? NO ... GO TO F6 1
YES 5

A. WHICH QUESTIONS WERE THOSE?

Q.______ Q.______ Q._____
Q.______ Q.______ Q._____
Q.______ Q.______ Q._____

F6. DID THE RESPONDENT APPEAR OFFENDED (AS EXEMPLIFIED BY COMMENTS AND/OR FACIAL EXPRESSIONS) BY ANY OF THE QUESTIONS? NO ... GO TO F7 1
YES 5

A. WHICH QUESTIONS WERE THOSE?

Q.______ Q.______ Q._____
Q.______ Q.______ Q._____
Q.______ Q.______ Q._____

F7. HOW RELIABLE WOULD YOU RATE R'S RESPONSES TO THIS INTERVIEW? VERY RELIABLE 1
SOMEWHAT RELIABLE 2
SOMEWHAT UNRELIABLE 3
VERY UNRELIABLE 4
