KESKI-SUOMEN HYVINVOINTI-ALUE

Alcohol Risks (AUDIT)

ONE PORTION OF ALCOHOL EQUALS TO
A bottle of medium strength beer (0.33cl)
12cl wine
8cl strong wine or 4cl spritz

1. How often do you have beer, wine or other drinks containing alcohol?

☐ never	0
☐ monthly or less	1
☐ 2-4 times a month	2
☐ 2-3 times a week	3
☐ 4 times a week or more	4

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

☐ 1-2 drinks	0
☐ 3-4 drinks	1
☐ 5-6 drinks	2
☐ 7-9 drinks	3
☐ 10 drinks or more	4

3. How often do you have 6 or more drinks on an occasion when you are drinking?

☐ never	0
☐ less than monthly	1
☐ monthly	2
☐ weekly	3
☐ daily or almost daily	4

4. How often during the past year have you found that you were not able to stop drinking once you had started?

☐ never	0
☐ less than monthly	1
☐ monthly	2
☐ weekly	3
☐ daily or almost daily	4

5. How often during the past year have you failed to do what was normally expected of you because of drinking?

☐ never	0
☐ less than monthly	1
☐ monthly	2
☐ weekly	3
☐ daily or almost daily	4

6. How often during the past year have you needed a first drink in the morning to get yourself going after heavy drinking session?

☐ never	0
☐ less than monthly	1
☐ monthly	2
☐ weekly	3
☐ daily or almost daily	4

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

☐ never	0
☐ less than monthly	1
☐ monthly	2
☐ weekly	3
☐ daily or almost daily	4

8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?

☐ never	0
☐ less than monthly	1
☐ monthly	2
☐ weekly	3
☐ daily or almost daily	4

9. Have you or has someone else been injured as a result of your drinking?

☐ no	0
☐ yes, but not in the past year	2
☐ yes, during the past year	4

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

☐ never	0
☐ yes, but not in the past year	2
☐ yes, during the past year	4

Total score _____

Your risk consumption of alcohol is:

0-7	Low
8-10	Elevated
11-14	Clearly elevated, indication of high consumption
15-19	High, possible alcohol dependence
20-40	Very high

Source: WHO, Audit -test

ALCOHOL USE DURING PREGNANCY

Have you used/do you use alcohol during your pregnancy?

☐ **No** ☐ **Yes**

If you answered yes, please explain the situation and how many portions you consumed.

_____

_____

SURVEY REGARDING CIGARETTES, MOIST SNUFF, MEDICATIONS AND DRUGS

Alleviivaa sopiva vaihtoehto.

☐ **I do not smoke**

☐ **I smoke occasionally**

☐ **I smoke daily.**

How many cigarettes per day? _____

☐ **I am exposed to passive smoking**

☐ **I am not exposed to passive smoking**

☐ **I have stopped smoking during pregnancy.**

Date: _____

USE OF MOIST SNUFF:

☐ **I do not use moist snuff**

☐ **I use moist snuff**

MEDICATION

1. Do you use prescription medication?

☐ **No**

☐ **Yes What prescription medication?**

_____

_____

_____

_____

2. Have you ever used medication to get high?

☐ **No** ☐ **Yes**

DRUGS

1.Have you ever used drugs?

☐ **No** ☐ **Yes**

What drugs?

_____

_____

_____

2. Have you ever used drugs intravenously?

☐ **No** ☐ **Yes**

What drugs?

_____

_____

_____

3. Have you been treated for substance abuse?

☐ **No** ☐ **Yes**

USE OF ALCOHOL AND DRUGS BY SPOUSE

1. Would you like to discuss your spouse's substance use?

☐ **No** ☐ **Yes**

2. Has your spouse received treatment for substance abuse?

☐ **No** ☐ **Yes**