



Post Office Box 237  
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**Drug Usage Questionnaire**

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

- Are You Now Or Have You In The Past Used The Following Drugs:
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Narcotics: ( Heroin, Morphine, Demerol, Methadone, Codeine, Oxycodone, Hydrocodone, Etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Barbituates: (Amytal, Phenobarbital, Seconal, Nembutal, Butalbatol, Pentobarbital, Etc.)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Marijuana Or Hashish  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Amphetamines: ( Benzedrine, Dexedrine, Methedrine, Etc,                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Cocaine Or Crack  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Hallucinogens: (Lsd, Dmt, Mescaline, Peyote, Psilocybin, Etc.                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Tranquilers, Sedative Hypnotics Or Inhalants  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other: _____  | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes, Please Give Details:

Type	Quantity	Frequency	Dates

Have You Ever Sought Treatment Because Of Drug Usage?  Yes  No

If Yes, State Dates And Name Of Doctors And Institutions Consulted: \_\_\_\_\_

Have You Ever Been Arrested Or Charged In Connection With Drugs?  Yes  No

If Yes, Give Dates And Details: \_\_\_\_\_

Please Indicate Any Additional Information: \_\_\_\_\_

Dated At \_\_\_\_\_ This \_\_\_\_\_ Day Of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature Of Proposed Insured