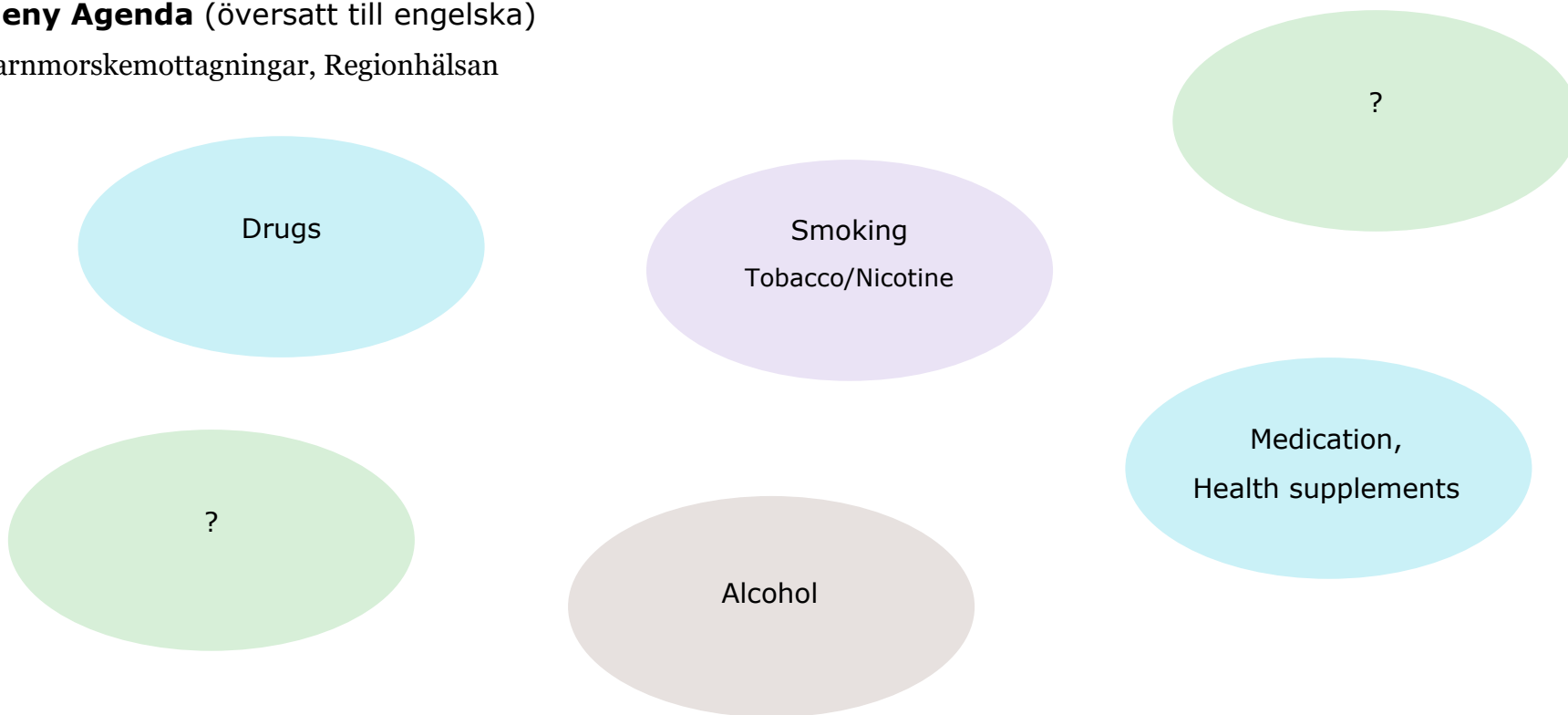




Meny Agenda (översatt till engelska)

Barnmorskemottagningar, Regionhälsan



AUDIT (english)

Below you will find a few questions concerning your drinking habits during the past year.

Please mark the alternative that applies to you. Thank you for answering the questions as accurately and honestly as possible.

One "standard drink"



HOW OLD ARE YOU? _____

MALE

FEMALE

1. How often do you have a drink containing alcohol?	NEVER <input type="checkbox"/>	MONTHLY OR LESS <input type="checkbox"/>	2-4 TIMES A MONTH <input type="checkbox"/>	2-3 TIMES A WEEK <input type="checkbox"/>	4 OR MORE TIMES A WEEK <input type="checkbox"/>
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2 <input type="checkbox"/>	3-4 <input type="checkbox"/>	5-6 <input type="checkbox"/>	7-9 <input type="checkbox"/>	10 OR MORE <input type="checkbox"/>
3. How often do you have six or more drinks on one occasion?	NEVER <input type="checkbox"/>	LESS THAN MONTHLY <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	DAILY OR ALMOST DAILY <input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	NEVER <input type="checkbox"/>	LESS THAN MONTHLY <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	DAILY OR ALMOST DAILY <input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	NEVER <input type="checkbox"/>	LESS THAN MONTHLY <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	DAILY OR ALMOST DAILY <input type="checkbox"/>
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	NEVER <input type="checkbox"/>	LESS THAN MONTHLY <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	DAILY OR ALMOST DAILY <input type="checkbox"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	NEVER <input type="checkbox"/>	LESS THAN MONTHLY <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	DAILY OR ALMOST DAILY <input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	NEVER <input type="checkbox"/>	LESS THAN MONTHLY <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	DAILY OR ALMOST DAILY <input type="checkbox"/>
9. Have you or someone else been injured as a result of your drinking?	NO <input type="checkbox"/>		YES, BUT NOT IN THE LAST YEAR <input type="checkbox"/>		YES, DURING THE LAST YEAR <input type="checkbox"/>
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	NO <input type="checkbox"/>		YES, BUT NOT IN THE LAST YEAR <input type="checkbox"/>		YES, DURING THE LAST YEAR <input type="checkbox"/>

Thank you very much for your participation!

Fetal image

