



# Drug Questionnaire

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Today's Date:

Agent:

Full Name:

Male or Female?

Height and weight:

Date of Birth:

1. Are you now using or have you in the past used the following drugs (except under physician's instructions)?

- a) Opium derivatives (for example Heroin, Morphine, Demerol, Methadone)  
    \_\_\_ Yes \_\_\_ No
- b) Barbiturates (for example Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital)  
    \_\_\_ Yes \_\_\_ No
- c) Cannabis (for example Hashish, Marijuana)  
    \_\_\_ Yes \_\_\_ No
- d) Amphetamines (for example Benzedrine, Bexadrine, Methedrine, Ecstasy, Ice)  
    \_\_\_ Yes \_\_\_ No
- e) Cocaine (Crack)  
    \_\_\_ Yes \_\_\_ No
- f) Hallucinogens (for example LSD, DMT, Mescaline, Peyote, Psilocybin)  
    \_\_\_ Yes \_\_\_ No
- g) IV Drugs  
    \_\_\_ Yes \_\_\_ No
- h) Other:  
    \_\_\_ Yes \_\_\_ No

If yes, please give details:

Type	Usual Quantity	Frequency of Use	Type (oral, inhaled, smoked, injection)	From (date)	To (date)

2. Have you ever sought medical treatment because of drug usage? \_\_\_ Yes \_\_\_ No  
If yes, list dates consulted and outcome.
  
3. Have you ever been told or was it ever recommended that you seek treatment?  
\_\_\_ Yes \_\_\_ No If yes, give details.
  
4. Have you ever been convicted of a drug-related activity? \_\_\_ Yes \_\_\_ No  
If yes, give details.
  
5. Are you now drug free? \_\_\_ Yes \_\_\_ No If yes, when did usage stop?
  
6. Please list any additional information you feel is important.