Vineville Internal Medicine

Patient's Name: _____ Date: ____/____/_____

Drug Abuse Screening Test (DAST)			
These Questions Refer to the Past 12 Months.			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family or missed work because of your use of drugs?	Yes	No
8	Have you engaged in illegal activites in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawl symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg; memory loss, hepatitis, convulsions, bleeding)?	Yes	No
11	Have you abused prescription drugs?	Yes	No
12	Can you get through the week without using drugs when you want (other than those required for medical reasons)?	Yes	No
13	Do you abuse drugs on a continuous basis?	Yes	No
14	Do you try to limit your drug use in certain situations?	Yes	No
15	Have you ever gone to anyone for help for a drug problem?	Yes	No
16	Have you ever been in a hospital for medical problems related to drug use?	Yes	No
17	Have you ever been involved in a treatment program specifically related to drug use?	Yes	No
18	Have you been treated as an outpatient for problems related to drug abuse?	Yes	No

CC: Patient Chart

Revised 3/26/13