

Drug and Substance Usage Questionnaire

First Name : _____ Last Name : _____
 Policy Number : _____ Date of Birth : _____

1. a) Have you used cannabis (such as marijuana or hashish) in the past five (5) years? If yes, please complete the following: Yes No

Type(s)	Quantity	Frequency	Date first used	Date last used
Vaping				
Inhaled (not vaped)				
External use (oil, cream)				
Edible/ingested				

b) Have you used cannabis for medicinal purpose (prescribed by a healthcare professional)? Yes No
 If yes, please specify the reason for cannabis usage: _____

c) In the past twelve (12) months, have you used cannabis mixed with nicotine? Yes No

2. Have you ever used any other drugs or prescription medications that weren't prescribed to you? Yes No
 If yes, please indicate which of the following applies to you:

Type(s)	Quantity	Frequency	Date first used	Date last used
Amphetamines (Speed, Meth, Chalk, Crystal, Glass, Crystal meth, etc.)				
Anabolic steroids (Anadrol, Oxandrin, Testosterone, etc.)				
Barbiturates (Amytal, Phenobarbital, Seconal, Nembutal, etc.)				
Cocaine (Coke, Blow, Snow, Crack, Candy, etc.)				
Ecstasy (MDMA, Molly, E, etc.)				
Hallucinogens (LSD, Acid, DMT, Mescaline, Peyote, Psilocybin (magic mushrooms), etc.)				
Opiates (Codeine, Heroin, Morphine, Methadone, narcotics, etc.)				
Intravenous use (specify) :				
Other (specify):				

3. Have you ever consulted a doctor or received treatment because of any drug use? Yes No
 If yes, indicate the dates and names of physicians, hospitals or treatment centers involved and type of treatment. _____

4. Have you ever lost your job, been charged with impaired driving or been arrested due to the influence of alcohol or drug(s)? Yes No
 If yes, please give details: _____

5. Do you presently consume alcoholic beverages? If yes, specify below: Yes No

Amount	Wine (glasses)	Beer (bottles)	Liquor (ounces)
Daily			
Weekly			
Monthly			
Yearly			

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

Signature of the person to be insured (parent or legal guardian if a minor) _____ Date _____