

## Drug and Substance Usage Questionnaire

First Name : \_\_\_\_\_ Last Name : \_\_\_\_\_  
 Policy Number : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

1. Have you ever used any drug(s)?  Yes  No

If yes, please indicate which of the following applies to you:

- Amphetamines (speed, uppers, Dexedrine (dexies), crystal meth, Methedrine, ice, Benzedrine, etc.)
- Anabolic steroids (roids, gear, juice, etc.)
- Barbiturates (amytal, Phenobarbital, Seconal, Nembutal, etc.)
- Cocaine (coke, blow, snow, crack, etc.)
- Hallucinogens (LSD, acid, DMT, Mescaline, Peyote, Psilocybin (magic mushrooms), etc.)
- Ecstasy (meth amphetamine, MDMA, ecky, molly, E's, etc.)
- Marijuana mixed with nicotine or hashish mixed with nicotine
- Marijuana (cannabis, dope, hooch, grass, pot, hashish, THC,CBD, etc.)
- Opium and derivatives (heroin, morphine, Demerol, Percocet, methadone, codeine, pethidine, smack, etc.)
- Solvents (glue, aerosol, thinners, nitrous oxide, petrol, etc.)
- IV drug use: \_\_\_\_\_
- Other (specify):** \_\_\_\_\_

2. (a) If you have answered yes to question 1, please complete the following:

Type(s)	Quantity	Frequency	Date first used	Date last used

(b) If you have answered yes to marijuana usage, please specify:  non-prescribed use  medicinal use as prescribed by a healthcare professional.

Please specify the reason for marijuana usage:

\_\_\_\_\_

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. \_\_\_\_\_

\_\_\_\_\_

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?  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 \_\_\_\_\_