

Driver Wellness & Safety Division Alcohol and Drug Questionnaire

To submit your form electronically, please visit: <https://mymva.maryland.gov/go/web/DocUpload>

Or submit by mail at:

MDOT MVA, Division of Driver Wellness and Safety, Room 124, 6601 Ritchie Highway, NE, Glen Burnie, MD 21062

Section A

Driver License Number		Today's Date	
Last Name	First	Middle	Date of Birth

Section B

- Have you ever drank alcohol? Yes No
If yes, what was the date of your last drink? _____
If you DID NOT drink alcohol in the past year, skip to question 9.
Choose the answer that most closely reflects your ALCOHOL USE IN THE PAST YEAR.
- How often do you have a drink containing alcohol?
Less than twice monthly Up to four times monthly Up to three times weekly More than four times weekly
- When drinking, how many drinks do you usually have at a time?
1-2 3-4 5-6 More than 6
- How often have you found that you were not able to stop drinking once you started?
Never Once monthly Weekly Almost daily
- How often have you failed to do what was normally expected of you because of drinking?
Never Once monthly Weekly Almost daily
- How often have you needed a first drink in the morning to get yourself going?
Never Once monthly Weekly Almost daily
- How often have you had a feeling of guilt after drinking?
Never Once monthly Weekly Almost daily
- How often have you been UNABLE to remember what happened the night before drinking?
Never Once monthly Weekly Almost daily
- Have you or someone else been injured as a result of your drinking?
Yes, during the past year Yes, but not in the past year Never
- Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggest you cut down?
Yes, during the past year Yes, but not in the past year Never
- Do you think you have ever had a problem with your alcohol use? Yes No
- Have you ever been in an alcohol treatment program? Yes No
If yes, provide name(s) and date(s) of treatment: _____
- Do you attend self-help meetings? Yes No
- Have you ever been cited for drinking and driving? Yes, number of times: _____ No

Name:	Driver's License Number
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Section C - Drug Use

1. Have you ever used illegal drugs? Yes No
If yes, what drug(s) and when was the last day of use? _____
2. Have you ever misused or abused prescription drugs or pain medication? Yes No
If yes, what drug(s) and when was the last day of use? _____
3. Have you ever been in a drug treatment program? Yes No
If yes, provide name(s) and date(s) of treatment: _____
4. Do you attend self-help meetings? Yes, number of meetings per week _____ No

Use the following space for additional information and comments:

Section D

I certify that the information I have provided is true and complete to the best of my knowledge and belief.

Signature _____

Date _____

Daytime Phone _____