

Section 3C - MEDICINE EXPERIENCES

1a. Now I'm going to ask you about some experiences that people have reported in connection with their use of medicines or drugs ON THEIR OWN that we just talked about. As I read each experience, please tell me if this has ever happened to you.

b. Did this happen in the last 12 months?

In your entire life, did you EVER ... (PAUSE)
(Repeat phrase frequently)

(1) Find that your usual amount of a medicine or drug had much less effect on you than it once did?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A1 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B1 *in column d*

(2) Find that you had to use much more of a medicine or drug to get the effect you wanted?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A2 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B2 *in column d*

(3) The next few questions are about the bad aftereffects that people may have when the effects of a medicine or drug are wearing off. This includes the morning after using it or in the first few days after stopping or cutting down on it. Did you EVER. . .

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A3 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B3 *in column d*

Sleep more than usual (when the effects of a medicine or drug were wearing off)?

(4) Feel weak or tired?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A4 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B4 *in column d*

(5) Feel depressed?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A5 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B5 *in column d*

(6) Find your heart beating fast (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A6 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B6 *in column d*

(7) Have nausea or vomiting?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A7 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B7 *in column d*

(8) Yawn a lot?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A8 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B8 *in column d*

(9) Have runny eyes or a runny nose (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A9 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B9 *in column d*

(10) Eat more than usual or gain weight?

1 Yes \longrightarrow
 2 No - *Go to next*
N3CQ1A10 *experience*

1 Yes \longrightarrow
 2 No - *Mark "Yes"*
N3CQ1B10 *in column d*

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 40) N3CD*Q1C%</i> % * *	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 40) N3CD*Q1E%</i> % * *
1 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D1 experience	1 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
2 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D2 experience	2 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
3 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D3 experience	3 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
4 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D4 experience	4 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
5 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D5 experience	5 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
6 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D6 experience	6 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
7 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D7 experience	7 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
8 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D8 experience	8 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
9 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D9 experience	9 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
10 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D10 experience	10 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

1a. Did you EVER ... (PAUSE)
(Repeat phrase frequently)

b. Did this happen in the last 12 months?

(11) Feel anxious or nervous?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A11 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B11 *in column d*

(12) Have muscle aches or cramps (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A12 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B12 *in column d*

(13) Have a fever?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A13 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B13 *in column d*

(14) Become so restless you fidgeted, paced or couldn't sit still?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A14 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B14 *in column d*

(15) Move or talk much more slowly than usual (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A15 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B15 *in column d*

(16) Find your pupils dilating or your hair standing up?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A16 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B16 *in column d*

(17) Have unpleasant dreams that often seemed real?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A17 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B17 *in column d*

(18) See, feel or hear things that weren't really there (when the effects of a medicine or drug were wearing off)?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A18 *experience,*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B18 *in column d*

(19) Feel shaky or have shaky or trembling hands?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A19 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B19 *in column d*

(20) Have trouble falling asleep or staying asleep?

1 Yes \longrightarrow
2 No - *Go to next*
N3CQ1A20 *experience*

1 Yes \longrightarrow
2 No - *Mark "Yes"*
N3CQ1B20 *in column d*

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 40) N3CD*Q1C%</i>			d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 40) N3CD*Q1E%</i>		
%	*	*		%	*	*
11	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D11 experience	11	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
12	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D12 experience	12	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
13	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D13 experience	13	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
14	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D14 experience	14	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
15	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D15 experience	15	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
16	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D16 experience	16	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
17	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D17 experience	17	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
18	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D18 experience	18	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
19	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D19 experience	19	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
20	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D20 experience	20	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

1a. Did you EVER ... <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	
(21) Have fits or seizures (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A21 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B21 in column d
(22) Become more irritable than usual?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A22 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B22 in column d
(23) Eat less than usual or lose weight?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A23 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B23 in column d
(24) Feel angry, combative or aggressive (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A24 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B24 in column d
(25) Have a headache?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A25 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B25 in column d
(26) Find yourself sweating?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A26 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B26 in column d
(27) Have chills (when the effects of a medicine or drug were wearing off)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A27 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B27 in column d
(28) Have stomach pain?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to Check Item 3.19 N3CQ1A28	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B28 in column d
CHECK ITEM 3.19 Are at least 2 items marked "Yes" in 1c(3)-1c(28) for at least 1 medicine or drug?	1 <input type="checkbox"/> Yes N3CCK319 2 <input type="checkbox"/> No - Go to Check Item 3.20	
(28-1) You just mentioned that you had SOME bad aftereffects when stopping or cutting down on your use of medicines or drugs in the last 12 months. Did at least 2 of these experiences happen around the same time DURING the last 12 months?		1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to Check Item N3CQ1B281 3.20
CHECK ITEM 3.20 Are at least 2 items marked "Yes" in 1e(3)-1e(28) for at least 1 medicine or drug?	1 <input type="checkbox"/> Yes N3CCK320 2 <input type="checkbox"/> No - Skip to 1a(29)	

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 40) N3CD*Q1C%</i>		d. Did this happen before 12 months ago, that is before last <i>(Month one year ago)?</i>		e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 40) N3CD*Q1E%</i>		
%	*	%	*	%	*	
21	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D21 <i>experience</i>	21	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
22	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D22 <i>experience</i>	22	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
23	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D23 <i>experience</i>	23	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
24	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D24 <i>experience</i>	24	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
25	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D25 <i>experience</i>	25	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
26	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D26 <i>experience</i>	26	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
27	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D27 <i>experience</i>	27	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
28	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to Check Item</i> N3CQ1D28 3.19	28	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH
28-1	1 <input type="checkbox"/> SED 3 <input type="checkbox"/> MAR 5 <input type="checkbox"/> STIM 7 <input type="checkbox"/> HAL 9 <input type="checkbox"/> HER	2 <input type="checkbox"/> PAN 4 <input type="checkbox"/> COC 6 <input type="checkbox"/> CLB 8 <input type="checkbox"/> SOLV 10 <input type="checkbox"/> OTH				

Section 3C - MEDICINE EXPERIENCES (Continued)

	b. Did this happen in the last 12 months?	
<p>(28-2) You (just/also) mentioned that you had SOME bad aftereffects when stopping or cutting down on your use of medicines or drugs BEFORE 12 months ago. Did at least 2 of these experiences happen around the same time BEFORE 12 months ago?</p>		
<p>1a. In your entire life, did you EVER ... <i>(Repeat phrase frequently)</i></p>		
<p>(29) Take more of the same or a similar medicine or drug to get over or avoid any of these bad aftereffects?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A29 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B29 in column d</p>
<p>(30) More than once WANT to stop or cut down on using any of these medicines or drugs?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A30 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B30 in column d</p>
<p>(31) More than once TRY to stop or cut down on using any of these medicines or drugs but found you couldn't do it?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A31 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B31 in column d</p>
<p>(32) Often use a medicine or drug in larger amounts or for a much longer period than you meant to?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A32 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B32 in column d</p>
<p>(33) Have a period when you spent a lot of time using a medicine or drug or getting over its bad aftereffects?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A33 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B33 in column d</p>
<p>(34) Have a period when you spent a lot of time making sure you always had enough of a medicine or drug available?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A34 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B34 in column d</p>
<p>(35) Give up or cut down on activities that were important to you in order to use a medicine or drug – like work, school, or associating with friends or relatives?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A35 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B35 in column d</p>
<p>(36) Give up or cut down on activities that you were interested in or that gave you pleasure in order to use a medicine or drug?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A36 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B36 in column d</p>
<p>(37) Continue to use a medicine or drug even though you knew it was making you feel depressed, uninterested in things, or suspicious or distrustful of other people?</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1A37 experience</p>	<p>1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B37 in column d</p>

Section 3C - MEDICINE EXPERIENCES (Continued)

Section 3C - MEDICINE EXPERIENCES (Continued)		
c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 40) N3CD*Q1C%</i>	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 40) N3CD*Q1E%</i>
	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D282 <i>experience</i>	28-2 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
29 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D29 <i>experience</i>	29 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
30 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D30 <i>experience</i>	30 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
31 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D31 <i>experience</i>	31 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
32 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D32 <i>experience</i>	32 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
33 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D33 <i>experience</i>	33 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
34 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D34 <i>experience</i>	34 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
35 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D35 <i>experience</i>	35 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
36 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D36 <i>experience</i>	36 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
37 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - <i>Go to next</i> N3CQ1D37 <i>experience</i>	37 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

1a. In your entire life, did you EVER ... (PAUSE) (Repeat phrase frequently)	b. Did this happen in the last 12 months?	
(38) Continue to use a medicine or drug even though you knew it was causing you a health problem or making a health problem worse?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A38 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B38 in column d
(39) Feel a very strong urge or desire to use a medicine or drug?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A39 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B39 in column d
(40) Want a medicine or drug so badly that you couldn't think of anything else?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A40 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B40 in column d
(41) Have arguments with your spouse or partner or family or friends as a result of your medicine or drug use?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A41 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B41 in column d
(42) Continue to use a medicine or drug even though it was causing you trouble with your family or friends?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A42 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B42 in column d
(43) Get into physical fights while under the influence of a medicine or drug?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A43 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B43 in column d
(44) Have job or school troubles as a result of your medicine or drug use - like missing too much work, not doing your work well, being demoted or losing a job, or being suspended, expelled or dropping out of school?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A44 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B44 in column d
(45) Continue to use a medicine or drug even though it was causing you problems at school or work?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A45 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B45 in column d
(46) Have a period when your medicine or drug use or your being sick from medicine or drug use often interfered with taking care of your home or family?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A46 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B46 in column d
(47) More than once drive a car, motorcycle, truck, boat, or other vehicle when you were under the influence of a medicine or drug?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to next N3CQ1A47 experience	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B47 in column d
(48) Find yourself under the influence of a medicine or drug or feeling its aftereffects in situations that increased your chances of getting hurt - like swimming; using heavy machinery or equipment; or walking in a dangerous area or around heavy traffic?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Go to Check Item N3CQ1A48 3.21	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - Mark "Yes" N3CQ1B48 in column d

Section 3C - MEDICINE EXPERIENCES (Continued)

c. During the last 12 months, which medicines or drugs did this happen with? <i>(SHOW FLASHCARD 40) N3CD*Q1C%</i> % * *	d. Did this happen before 12 months ago, that is before last (Month one year ago)?	e. Which medicines or drugs did this happen with before 12 months ago? <i>(SHOW FLASHCARD 40) N3CD*Q1E%</i> % * *
38 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D38 experience	38 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
39 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D39 experience	39 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
40 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D40 experience	40 1 <input type="checkbox"/> SET 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
41 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D41 experience	41 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
42 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D42 experience	42 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
43 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D43 experience	43 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
44 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D44 experience	44 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
45 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D45 experience	45 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
46 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D46 experience	46 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
47 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to next N3CQ1D47 experience	47 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH
48 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH	1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> No - Go to Check Item N3CQ1D48 3.21	48 1 <input type="checkbox"/> SED 2 <input type="checkbox"/> PAN 3 <input type="checkbox"/> MAR 4 <input type="checkbox"/> COC 5 <input type="checkbox"/> STIM 6 <input type="checkbox"/> CLB 7 <input type="checkbox"/> HAL 8 <input type="checkbox"/> SOLV 9 <input type="checkbox"/> HER 10 <input type="checkbox"/> OTH

Section 3C - MEDICINE EXPERIENCES (Continued)

CHECK ITEM 3.21	Are at least 2 boxes in Box 1, (2 or 3), 4-12 marked "Yes" in 1a, column e?	2a. You just mentioned some experiences you had with <i>(Name of drug category)</i> in the past, that is, before 12 months ago. Before last <i>(Month one year ago)</i> was there ever a period when SOME of these experiences with <i>(Name of drug category)</i> were happening around the same time most days for at least a month (PAUSE), on and off for a few months or longer (PAUSE) or within the same 1-year period?	b. About how old were you the FIRST time SOME of these experiences with <i>(Name of drug category)</i> BEGAN to happen around the same time?	c. In your ENTIRE LIFE how many separate periods like this did you have when some of these experiences with <i>(Name of drug category)</i> were happening around the same time? By separate periods, I mean times separated by at least a year when you EITHER STOPPED using <i>(Name of drug category)</i> entirely (PAUSE) OR you didn't have any of the experiences you just mentioned with <i>(Name of drug category)</i> .
N3CCK321	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.24 <i>Mark corresponding category below and ask 2 a-g for each marked category.</i>			
1 <input type="checkbox"/> Sedatives or Tranquilizers N3CD1CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD1Q2A drug category	_____ Age N3CD1Q2B	_____ Number N3CD1Q2C	
2 <input type="checkbox"/> Painkillers N3CD2CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD2Q2A drug category	_____ Age N3CD2Q2B	_____ Number N3CD2Q2C	
3 <input type="checkbox"/> Marijuana N3CD3CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD3Q2A drug category	_____ Age N3CD3Q2B	_____ Number N3CD3Q2C	
4 <input type="checkbox"/> Cocaine or Crack N3CD4CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD4Q2A drug category	_____ Age N3CD4Q2B	_____ Number N3CD4Q2C	
5 <input type="checkbox"/> Stimulants N3CD5CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD5Q2A drug category	_____ Age N3CD5Q2B	_____ Number N3CD5Q2C	
6 <input type="checkbox"/> Club drugs N3CD6CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD6Q2A drug category	_____ Age N3CD6Q2B	_____ Number N3CD6Q2C	
7 <input type="checkbox"/> Hallucinogens N3CD7CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD7Q2A drug category	_____ Age N3CD7Q2B	_____ Number N3CD7Q2C	
8 <input type="checkbox"/> Inhalants/Solvents N3CD8CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD8Q2A drug category	_____ Age N3CD8Q2B	_____ Number N3CD8Q2C	
9 <input type="checkbox"/> Heroin N3CD9CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to next N3CD9Q2A drug category	_____ Age N3CD9Q2B	_____ Number N3CD9Q2C	
10 <input type="checkbox"/> Other N3CD10CK321	1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> No - SKIP to N3CD10Q2A Check Item 3.24	_____ Age N3CD10Q2B	_____ Number N3CD10Q2C	

Section 3C - MEDICINE EXPERIENCES (Continued)

<p>CHECK ITEM 3.22</p> <p>Is number in 2c, 2 or more or unknown?</p>	<p>d. In your ENTIRE LIFE what was the LONGEST period you had when SOME of these experiences with (Name of drug category) were happening around the same time?</p>	<p>e. About how old were you the MOST RECENT time when some of these experiences BEGAN to happen around the same time?</p>	<p>f. How long did this period last when some of these experiences with (Name of drug category) were happening around the same time?</p> <p>N3CD*Q2FM N3CD*Q2FY</p>	<p>CHECK ITEM 3.23</p> <p>Is at least 1 item marked in 1, column c, items (1)-(38) or (41)-(48)?</p>	<p>g. About how old were you when you FINALLY STOPPED having these problems with (Name of drug category)? By finally stopped, I mean they never started happening again.</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD1CK322</p>	<p>N3CD1Q2DCONT ____ Month(s) OR ____ Year(s) N3CD1Q2DUNIT</p>	<p>N3CD1Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD1Q2FCONT ____ Month(s) OR ____ Year(s) N3CD1Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD1CK323</p>	<p>N3CD1Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD2CK322</p>	<p>N3CD2Q2DCONT ____ Month(s) OR ____ Year(s) N3CD2Q2DUNIT</p>	<p>N3CD2Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD2Q2FCONT ____ Month(s) OR ____ Year(s) N3CD2Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD2CK323</p>	<p>N3CD2Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD3CK322</p>	<p>N3CD3Q2DCONT ____ Month(s) OR ____ Year(s) N3CD3Q2DUNIT</p>	<p>N3CD3Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD3Q2FCONT ____ Month(s) OR ____ Year(s) N3CD3Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD3CK323</p>	<p>N3CD3Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD4CK322</p>	<p>N3CD4Q2DCONT ____ Month(s) OR ____ Year(s) N3CD4Q2DUNIT</p>	<p>N3CD4Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD4Q2FCONT ____ Month(s) OR ____ Year(s) N3CD4Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD4CK323</p>	<p>N3CD4Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD5CK322</p>	<p>N3CD5Q2DCONT ____ Month(s) OR ____ Year(s) N3CD5Q2DUNIT</p>	<p>N3CD5Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD5Q2FCONT ____ Month(s) OR ____ Year(s) N3CD5Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD5CK323</p>	<p>N3CD5Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD6CK322</p>	<p>N3CD6Q2DCONT ____ Month(s) OR ____ Year(s) N3CD6Q2DUNIT</p>	<p>N3CD6Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD6Q2FCONT ____ Month(s) OR ____ Year(s) N3CD6Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD6CK323</p>	<p>N3CD6Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD7CK322</p>	<p>N3CD7Q2DCONT ____ Month(s) OR ____ Year(s) N3CD7Q2DUNIT</p>	<p>N3CD7Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD7Q2FCONT ____ Month(s) OR ____ Year(s) N3CD7Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD7CK323</p>	<p>N3CD7Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD8CK322</p>	<p>N3CD8Q2DCONT ____ Month(s) OR ____ Year(s) N3CD8Q2DUNIT</p>	<p>N3CD8Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD8Q2FCONT ____ Month(s) OR ____ Year(s) N3CD8Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD8CK323</p>	<p>N3CD8Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD9CK322</p>	<p>N3CD9Q2DCONT ____ Month(s) OR ____ Year(s) N3CD9Q2DUNIT</p>	<p>N3CD9Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD9Q2FCONT ____ Month(s) OR ____ Year(s) N3CD9Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Go to next drug category</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD9CK323</p>	<p>N3CD9Q2G ____ Age - SKIP to next drug category</p>
<p>1 <input type="checkbox"/> Yes →</p> <p>2 <input type="checkbox"/> No - SKIP to 2f</p> <p>N3CD10CK322</p>	<p>N3CD10Q2DCONT ____ Month(s) OR ____ Year(s) N3CD10Q2DUNIT</p>	<p>N3CD10Q2E ____ Age - Go to Check Item 3.23</p>	<p>N3CD10Q2FCONT ____ Month(s) OR ____ Year(s) N3CD10Q2FUNIT</p>	<p>1 <input type="checkbox"/> Yes - Skip to Check Item 3.24</p> <p>2 <input type="checkbox"/> No →</p> <p>N3CD10CK323</p>	<p>N3CD10Q2G ____ Age - Go to Check Item 3.24</p>

Section 3C - MEDICINE EXPERIENCES (Continued)

CHECK ITEM 3.24	Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, Column c for Sedatives/Tranquilizers?	1 <input type="checkbox"/> Yes N3CCK324 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.25</i>
<p>3. You just mentioned SOME experiences you had with sedatives or tranquilizers in the last 12 months.</p> <p>(a) When you had SOME of these experiences with sedatives or tranquilizers in the last 12 months, were you using them without a prescription?</p>		1 <input type="checkbox"/> Yes N3CQ3A 2 <input type="checkbox"/> No
<p>(b) During the last 12 months when you had some of these experiences with sedatives or tranquilizers, were you using them in LARGER AMOUNTS, MORE FREQUENTLY or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>		1 <input type="checkbox"/> Yes N3CQ3B 2 <input type="checkbox"/> No
CHECK ITEM 3.25	Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column e for sedatives/tranquilizers.	1 <input type="checkbox"/> Yes N3CCK325 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.26</i>
<p>4. You just mentioned SOME experiences you had with sedatives or tranquilizers around the same time BEFORE 12 months ago, that is, BEFORE last (Month one year ago).</p> <p>(a) During ANY of these times when you had SOME of these experiences with sedatives or tranquilizers BEFORE 12 months ago, were you using them without a prescription?</p>		1 <input type="checkbox"/> Yes N3CQ4A 2 <input type="checkbox"/> No - <i>SKIP to 4c</i>
<p>(b) Did ALL of these times BEFORE 12 months ago ONLY happen when you were using sedatives or tranquilizers without a prescription?</p>		1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 3.26</i> N3CQ4B 2 <input type="checkbox"/> No
<p>(c) During ANY of these times when you had SOME of those experiences with sedatives or tranquilizers BEFORE 12 months ago, were you using them in GREATER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.26</i> N3CQ4C
<p>5. Did ALL of those times BEFORE 12 months ago ONLY happen when you were using sedatives or tranquilizers in LARGER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>		1 <input type="checkbox"/> Yes N3CQ5 2 <input type="checkbox"/> No
CHECK ITEM 3.26	Are at least 2 Boxes, Box 1, (2 or 3), 4-12 marked in 1a, Column c for painkillers?	1 <input type="checkbox"/> Yes N3CCK326 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.27</i>
<p>6. You just mentioned SOME experiences you had with painkillers in the last 12 months.</p> <p>(a) When you had SOME of these experiences with painkillers in the last 12 months, were you using them without a prescription?</p>		1 <input type="checkbox"/> Yes N3CQ6A 2 <input type="checkbox"/> No
<p>(b) During the last 12 months when you had some of these experiences with painkillers, were you using them in LARGER AMOUNTS, MORE FREQUENTLY or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>		1 <input type="checkbox"/> Yes N3CQ6B 2 <input type="checkbox"/> No
CHECK ITEM 3.27	Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column e for painkillers?	1 <input type="checkbox"/> Yes N3CCK327 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.28</i>
<p>7. You just mentioned SOME experiences you had with painkillers around the same time BEFORE 12 months ago, that is, BEFORE last (Month one year ago).</p> <p>(a) During ANY of these times when you had SOME of these experiences with painkillers BEFORE 12 months ago, were you using them without a prescription?</p>		1 <input type="checkbox"/> Yes N3CQ7A 2 <input type="checkbox"/> No - <i>SKIP to 7c</i>

Section 3C - MEDICINE EXPERIENCES (Continued)

<p>7. (b) Did ALL of these times BEFORE 12 months ago ONLY happen when you were using painkillers without a prescription?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 3.28 N3CQ7B</i> 2 <input type="checkbox"/> No</p>															
<p>(c) During ANY of these times when you had SOME of those experiences with painkillers BEFORE 12 months ago, were you using them in GREATER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.28 N3CQ7C</i></p>															
<p>8. Did ALL of those times BEFORE 12 months ago ONLY happen when you were using painkillers in LARGER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes N3CQ8 2 <input type="checkbox"/> No</p>															
<p>CHECK ITEM 3.28 Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, Column c for stimulants?</p>	<p>1 <input type="checkbox"/> Yes N3CCK328 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.29</i></p>															
<p>9. You just mentioned SOME experiences you had with stimulants in the last 12 months.</p> <p>(a) When you had SOME of these experiences with stimulants in the last 12 months, were you using them without a prescription?</p>	<p>1 <input type="checkbox"/> Yes N3CQ9A 2 <input type="checkbox"/> No</p>															
<p>(b) During the last 12 months when you had some of these experiences with stimulants, were you using them in LARGER AMOUNTS, MORE FREQUENTLY or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes N3CQ9B 2 <input type="checkbox"/> No</p>															
<p>CHECK ITEM 3.29 Are at least 2 Boxes, Box 1, (2 or 3), 4-12, marked in 1a, column e for stimulants?</p>	<p>1 <input type="checkbox"/> Yes N3CCK329 2 <input type="checkbox"/> No - <i>SKIP to 12a</i></p>															
<p>10. You just mentioned SOME experiences you had with stimulants around the same time BEFORE 12 months ago that is, BEFORE last (<i>Month one year ago</i>).</p> <p>(a) During ANY of these times when you had SOME of these experiences with stimulants BEFORE 12 months ago, were you using them without a prescription?</p>	<p>1 <input type="checkbox"/> Yes N3CQ10A 2 <input type="checkbox"/> No - <i>SKIP to 10c</i></p>															
<p>(b) Did ALL of these times BEFORE 12 months ago ONLY happen when you were using stimulants without a prescription?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 12a</i> N3CQ10B 2 <input type="checkbox"/> No</p>															
<p>(c) During ANY of these times when you had SOME of those experiences with stimulants BEFORE 12 months ago, were you using them in GREATER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes N3CQ10C 2 <input type="checkbox"/> No - <i>SKIP to 12a</i></p>															
<p>11. Did ALL of those times BEFORE 12 months ago ONLY happen when you were using stimulants in LARGER AMOUNTS, MORE FREQUENTLY, or LONGER than prescribed or for a reason other than prescribed by a doctor?</p>	<p>1 <input type="checkbox"/> Yes N3CQ11 2 <input type="checkbox"/> No</p>															
<p>12a. In the last 12 months, did you more than once get arrested, held at a police station or have any other legal problems because of your medicine or drug use?</p>	<p>1 <input type="checkbox"/> Yes N3CQ12A 2 <input type="checkbox"/> No - <i>SKIP to 12c</i></p>															
<p>b. During the last 12 months, which medicines or drugs did this happen with? (<i>SHOW FLASHCARD 40</i>)</p>	<table border="0"> <tr> <td>1 <input type="checkbox"/> SED</td> <td>2 <input type="checkbox"/> PAN</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> MAR</td> <td>4 <input type="checkbox"/> COC</td> <td>N3CQ12B1-</td> </tr> <tr> <td>5 <input type="checkbox"/> STIM</td> <td>6 <input type="checkbox"/> CLB</td> <td>N3CQ12B10</td> </tr> <tr> <td>7 <input type="checkbox"/> HAL</td> <td>8 <input type="checkbox"/> SOLV</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> HER</td> <td>10 <input type="checkbox"/> OTH</td> <td></td> </tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	N3CQ12B1-	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	N3CQ12B10	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH	
1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN															
3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	N3CQ12B1-														
5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	N3CQ12B10														
7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV															
9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH															
<p>c. Did this happen before 12 months ago, that is before last (<i>Month one year ago</i>)?</p>	<p>1 <input type="checkbox"/> Yes N3CQ12C 2 <input type="checkbox"/> No - <i>SKIP to 13a</i></p>															

Section 3C - MEDICINE EXPERIENCES (Continued)

<p>12d. Which medicines or drugs did this happen with before 12 months ago? (SHOW FLASHCARD 40)</p>	<table> <tr> <td>1 <input type="checkbox"/> SED</td> <td>2 <input type="checkbox"/> PAN</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> MAR</td> <td>4 <input type="checkbox"/> COC</td> <td>N3CQ12D1-</td> </tr> <tr> <td>5 <input type="checkbox"/> STIM</td> <td>6 <input type="checkbox"/> CLB</td> <td>N3CQ12D10</td> </tr> <tr> <td>7 <input type="checkbox"/> HAL</td> <td>8 <input type="checkbox"/> SOLV</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> HER</td> <td>10 <input type="checkbox"/> OTH</td> <td></td> </tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	N3CQ12D1-	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	N3CQ12D10	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH	
1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN															
3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	N3CQ12D1-														
5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	N3CQ12D10														
7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV															
9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH															
<p>13a. In the last 12 months, did you use any medicine or drug to make you more alert or to enhance your mental performance, skills or abilities at work or in school?</p>	<table> <tr> <td>1 <input type="checkbox"/> Yes</td> <td></td> </tr> <tr> <td>2 <input type="checkbox"/> No – SKIP to 13c</td> <td>N3CQ13A</td> </tr> </table>	1 <input type="checkbox"/> Yes		2 <input type="checkbox"/> No – SKIP to 13c	N3CQ13A											
1 <input type="checkbox"/> Yes																
2 <input type="checkbox"/> No – SKIP to 13c	N3CQ13A															
<p>b. During the last 12 months, which medicines or drugs did this happen with? (SHOW FLASHCARD 40)</p>	<table> <tr> <td>1 <input type="checkbox"/> SED</td> <td>2 <input type="checkbox"/> PAN</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> MAR</td> <td>4 <input type="checkbox"/> COC</td> <td>N3CQ13B1-</td> </tr> <tr> <td>5 <input type="checkbox"/> STIM</td> <td>6 <input type="checkbox"/> CLB</td> <td>N3CQ13B10</td> </tr> <tr> <td>7 <input type="checkbox"/> HAL</td> <td>8 <input type="checkbox"/> SOLV</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> HER</td> <td>10 <input type="checkbox"/> OTH</td> <td></td> </tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN		3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	N3CQ13B1-	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	N3CQ13B10	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV		9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH	
1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN															
3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	N3CQ13B1-														
5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	N3CQ13B10														
7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV															
9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH															
<p>c. Did this happen before 12 months ago, that is before last (Month one year ago)?</p>	<table> <tr> <td>1 <input type="checkbox"/> Yes</td> <td>N3CQ13C</td> </tr> <tr> <td>2 <input type="checkbox"/> No – SKIP to Section 3D</td> <td></td> </tr> </table>	1 <input type="checkbox"/> Yes	N3CQ13C	2 <input type="checkbox"/> No – SKIP to Section 3D												
1 <input type="checkbox"/> Yes	N3CQ13C															
2 <input type="checkbox"/> No – SKIP to Section 3D																
<p>d. Which medicines or drugs did this happen with before 12 months ago? (SHOW FLASHCARD 40)</p>	<table> <tr> <td>1 <input type="checkbox"/> SED</td> <td>2 <input type="checkbox"/> PAN</td> <td rowspan="6">} N3CQ13D1- N3CQ13D10 Go to Section 3D</td> </tr> <tr> <td>3 <input type="checkbox"/> MAR</td> <td>4 <input type="checkbox"/> COC</td> </tr> <tr> <td>5 <input type="checkbox"/> STIM</td> <td>6 <input type="checkbox"/> CLB</td> </tr> <tr> <td>7 <input type="checkbox"/> HAL</td> <td>8 <input type="checkbox"/> SOLV</td> </tr> <tr> <td>9 <input type="checkbox"/> HER</td> <td>10 <input type="checkbox"/> OTH</td> </tr> </table>	1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	} N3CQ13D1- N3CQ13D10 Go to Section 3D	3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC	5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB	7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV	9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH				
1 <input type="checkbox"/> SED	2 <input type="checkbox"/> PAN	} N3CQ13D1- N3CQ13D10 Go to Section 3D														
3 <input type="checkbox"/> MAR	4 <input type="checkbox"/> COC															
5 <input type="checkbox"/> STIM	6 <input type="checkbox"/> CLB															
7 <input type="checkbox"/> HAL	8 <input type="checkbox"/> SOLV															
9 <input type="checkbox"/> HER	10 <input type="checkbox"/> OTH															