

Alcohol Screening Tests

Test

Audit

Questions Asked

The following questions pertain to your use of alcoholic beverages during the past year. A “drink” refers to a can or bottle of beer, a glass of wine, a wine cooler, or 1 cocktail or shot of hard liquor.

1. How often do you have a drink containing alcohol (never, 0 points; \leq monthly, 1 point; 2-4 times per month, 2 points; 2-3 times per week, 3 points; or 4 or more times per week, 4 points)
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (1-2 drinks, 0 points; 3-4 drinks, 1 point; 5-6 drinks, 2 points; 7-9 drinks, 3 points; \geq 10 drinks, 4 points)
3. How often do you have 6 or more drinks on 1 occasion? (Never, 0 points; $<$ monthly, 1 point; monthly, 2 points; weekly, 3 points; daily or almost daily, 4 points;)
4. How often during the last year have you found that you were not able to stop drinking once you had started? (Same as question No. 3)
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (Same as question No. 3)
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (Same as question No. 3)
7. How often during the last year have you had a feeling of guilt or remorse after drinking? (Same as question No. 3)
8. How often during the last year have you been unable to remember what happened the night before because you were drinking? (Same as question No. 3)
9. Have you or someone else been injured as a result of your drinking? (No, 0 points; yes, but not in the past year, 2 points; yes, during the past year, 4 points)

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10. Has a relative or friend, or a doctor or other health care worker been concerned about your drinking or suggested you cut down? (Same as question No. 9)

Scoring the AUDIT: Score to give for answer in column. Questions 1 to 8 are scored 0, 1, 2, 3, or 4. Questions 9 and 10 are scored 0, 2, or 4 only. The minimum score (for non-drinkers) is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption. Time required: 2 minutes.

Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption—II. *Addiction*. 1993;88:791-804. (PMID: 8329970)

The TWEAK is a screening instrument used to identify risk drinking during pregnancy.

Test

TWEAK

Questions Asked

T Tolerance: How many drinks can you hold (“hold” version; ≥ 6 drinks indicates tolerance), or how many drinks does it take before you begin to feel the first effects of the alcohol? (“high” version: ≥ 3 indicates tolerance)

W Worried: Have close friends or relatives worried or complained about your drinking in the past year?

E Eye openers: Do you sometimes take a drink in the morning when you first get up?

A Amnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

K Kut down: Do you sometimes feel the need to cut down on your drinking?

Scoring: 2 points each for tolerance or worried; 1 point each for eye opener, amnesia, or kut down; sum all points; total, 0-7 points.

Chang G, Wilkins-Haug L, Berman S, Goetz MA. The TWEAK: application in a prenatal setting. *J Stud Alcohol*. 1999 May;60(3):306-9 (PMID: 10371256).

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