Electronic Supplementary Material A:

Boden Screening Tool

1. In the past 3 months have you taken any of these substances? ☐ Yes ☐ No (*check all that apply)*:
   ☐ Marijuana ☐ Morphine ☐ Methadone
   ☐ Meperidine [Demerol] ☐ Oxycodone [Percodan] ☐ Propoxyphene [Darvon]
   ☐ Hydromorphone [Dilaudid] ☐ Fentanyl [Sublimaze] ☐ Buprenorphine [Suboxone]
   ☐ Diazepam [Valium] ☐ Cocaine ☐ Heroin
   ☐ Codeine ☐ Phenobarbital ☐ Clomipramine [Anafranil]
   ☐ Hydroxyzine [Vistaril] ☐ Theophylline ☐ Lithium
   ☐ Chlorpromazine [Thorazine] ☐ Clonidine [Catapres] ☐ Diphenhydramine [Benadryl] ☐ Hydrocodone [Vicodin] ☐ LSD
   ☐ Solvants/Aerosols

2. Has anyone in your family taken or is currently taking the substances listed above?
   ☐ Yes ☐ No
   If yes, who? _____
   List substance(s) _____

3. In the past month, how often did you drink:
   Beer: ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
   Wine: ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
   Wine Cooler: ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
   Liquor: ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently

4. Do you occasionally drink more alcohol or use more substances than you planned and/or spent more money on substances or alcohol than you planned?
   ☐ Yes ☐ No

5. Have you ever felt you ought to cut down on your drinking or substance use?
   ☐ Yes ☐ No

6. Have people annoyed you by criticizing your drinking or substance use?
   ☐ Yes ☐ No

7. Do you feel you may have trouble staying off alcohol or substances during your pregnancy?
   ☐ Yes ☐ No

8. If you have a partner, are you concerned about your partner's use of alcohol or substances?
   ☐ Yes ☐ No

9. Have you or anyone in your family ever had a substance abuse problem?
   ☐ Yes ☐ No
   If yes, who? _____
   List substance(s) _____

*Patient Name (printed)*_____ *Patient Signature*_____

*Reviewer/Entered into EPIC*_____/_____
*Date/Time*_____