Pediatric Substance Exposure Screening

Patient Name

Date of Birth

Date of Screening

Provider

Substance Exposure History

Known prenatal substance exposure?

If yes, indicate substance(s) (select all that apply)

Alcohol
Tobacco
Marijuana
Opioids
Stimulants

If other, specify:

Any current exposure to substances in environment?

If yes, indicate substance(s) (select all that apply)

Alcohol
Tobacco
Marijuana
Opioids
Stimulants

If other, specify:

Additional Notes