Drug Take Back Participant Survey

Count It! Lock It! Drop It!™

Today's Date: _____

Clear Form

Please check a box for the following questions.

1. **Where would you drop meds off if not here today?**
   ☐ _____ ☐ _____ ☐ _____

2. **What is your zip code?**
   ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

3. **Where are you living now?** ☐ in a city or the suburbs of a city
   ☐ in a town or suburbs of a town
   ☐ in the country (that is, not in a city or town)

4. **What is your age group?** ☐ 30 and under ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71+

5. **What is your gender?** ☐ Male ☐ Female

6. **Are you Hispanic or Latino?** ☐ Yes ☐ No

7. **What do you consider yourself to be? (*Check all that apply.*)**
   ☐ White ☐ Black or African American ☐ Alaska Native ☐ Other
   ☐ American Indian ☐ Native Hawaiian or Other Pacific Islander ☐ Asian American

8. **How did you hear about the Prescription Drug Take Back/Drop off? (*Check all that apply.*)**
   ☐ Family/ Friend ☐ Newspaper ☐ Pharmacy
   ☐ Medical Professional ☐ Radio ☐ Internet/E-mail
   ☐ Community Group ☐ Marquee ☐ Pizza Box
   ☐ My Coalition ☐ Other (*please specify*) _____

9. **What influenced your decision to drop off prescription medication(s) today? (*Check all that apply.*)**
   ☐ harm to environment ☐ wanted to get them out of the house to prevent non-medicinal use
   ☐ fear of getting robbed for these prescriptions ☐ Other (*please specify*) _____

10. **Whose prescription medication(s) are you dropping off today? (*Check all that apply.*)**
    ☐ Mine ☐ A family member ☐ A friend ☐ A neighbor ☐ A pet
    ☐ Unknown ☐ A patient(s) ☐ Other (*please specify*) _____

11. **How long have you had these prescription medication(s) that you are dropping off? (*Check all that apply if you are dropping off multiple drugs.*)**
    ☐ under 3 months ☐ 4-7 months ☐ 8-12 months ☐ more than 1 year ☐ more than 2 years

Please check a box for Yes or No, and supply additional info as needed for these final questions.	Yes	No
12. Would you support a policy that would allow for a permanent prescription drug take back box (e.g., at local pharmacies or police stations)? If No, why not? _____	☐	☐
13. Do you keep track of your prescription medication(s) (how many you should have left in the bottle)? If No, why not? _____	☐	☐
14. Have you ever had someone take your prescription medication(s) from you without your permission? ☐ Not sure; I do not keep track of my medications.	☐	☐
15. Do you lock up your prescription medication(s) (e.g., in a safe or lock box)?	☐	☐
16. Do you store your prescription medication(s) in a location where others in your house are unlikely to find them?	☐	☐
17. Do you believe that prescription drug abuse by teens is a problem in your community?	☐	☐
18. Do you believe that prescription drug abuse by adults is a problem in your community?	☐	☐

Count It! Lock It! Drop It!™