TOBACCO USE ASSESSMENT FORM

Patient’s Name ____________________________________________________ Date ______________

1. Do you use tobacco in any form?  yes___ no___

1A. If no, have you ever used tobacco in the past?  yes___ no___

   How long did you use tobacco?  years___ months___
   How long ago did you stop?  years___ months___

If you are not currently a tobacco user, no other questions should be answered.
Thank you for completing this form.

Questions 2 to 10 are for current tobacco users only.

2. If you smoke, what type? (check) How many? (number)
   Cigarettes ___________ cigarettes per day _____
   Cigars ___________
   Pipe ___________

3. If you chew / use snuff, what type? How much?
   Snuff ___________
   Chewing ___________

3A. How long do you keep a chew in your mouth? minutes _____

4. How many days of the week do you use tobacco?  7  6  5  4  3  2  1

5. How soon after you wake up do you first use tobacco?
   Within 30 minutes _____, more than 30 minutes _____

6. Does the person closest to you use tobacco?  yes___ no___

7. How interested are you in stopping your use of tobacco?
   not at all___ a little___ somewhat___ yes___ very much___

8. Have you tried to stop using tobacco before?  yes___ no___

8A. How long ago was your last try to stop?  years___ months___

9. Have you discussed stopping with your physician?  yes___ no___

10. If you decided to stop using tobacco completely during the next two weeks,
    how confident are you that you would succeed?
    not at all____, a little____, somewhat____, very confident____