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 _____ cigars per day _____
Pipe _____ bowls per day _____

3. **If you chew / use snuff**, what type? How much?

Snuff _____ days a can lasts _____
Chewing _____ pouches per week _____

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____