TOBACCO HISTORY

Name:_____ Date:_____

1. Tobacco product:

During the last 30 days, what kinds of tobacco did you use and, on the average, how much did you use?

- ☐ Cigarette - # cigarettes per day _____
- ☐ Smokeless tobacco - # tins or bags per week _____
- ☐ Cigar - # cigars per week _____
- ☐ Pipe - # bowls per day _____
- ☐ Chew cigar - # cigars chewed per week _____

2. When do you use tobacco?

- ☐ When around other tobacco users
- ☐ When drinking alcohol
- ☐ When under a lot of stress
- ☐ When relaxing
- ☐ When talking on the telephone
- ☐ When wanting to cheer up
- ☐ When drinking coffee, tea, or soda
- ☐ When driving
- ☐ After meals
- ☐ Other, please specify_____

3. Number of previous quit attempts:

- ☐ None (If none, go to question #7)
- ☐ 1 - 5
- ☐ 6 - 10
- ☐ 11 or more

4. How did you stop on previous quit attempts?

- ☐ Abrupt stop (cold turkey)
- ☐ Self-help materials
- ☐ Counseling from a doctor or other health care professional
- ☐ Gradual reduction, tapering
- ☐ Hypnosis
- ☐ Acupuncture
- ☐ A formal cessation program (with classes, group discussions
- ☐ A residential (inpatient) program
- ☐ Nicotine patches
- ☐ Nicotine gum
- ☐ Nicotine inhaler
- ☐ Nicotine nasal spray
- ☐ Zyban/Wellbutrin
- ☐ Nortriptyline
- ☐ Other medication, please specify_____
- ☐ Other, please specify _____

If you started using tobacco after a previous quit attempt why?

_____

5. Tobacco cessation medications:

Are you currently using medications to assist in quitting?

☐ Yes ☐ No ☐ D/K If yes, what kinds?

- ☐ Nicotine patches
- ☐ Nicotine gum
- ☐ Nicotine inhaler
- ☐ Nicotine nasal spray
- ☐ Zyban/Wellbutrin
- ☐ Nortriptyline
- ☐ Other medication, please specify_____

6. Withdrawal symptoms:

Which of the following symptoms, if any, have you had when you stopped using tobacco?

- ☐ Anger
- ☐ Frustration
- ☐ Anxiety
- ☐ Desire to smoke
- ☐ Shakiness
- ☐ Irritability
- ☐ Trouble sleeping
- ☐ Hunger/increased eating
- ☐ Nervousness/restlessness
- ☐ Fatigue
- ☐ Depression
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other_____

7. Social support system:

- ☐ Spouse
- ☐ Parent(s)
- ☐ Brother(s) or sister(s)
- ☐ Children
- ☐ Room mate
- ☐ Friends
- ☐ Co-workers
- ☐ Other_____
- ☐

8. Does your workplace have a policy that bans your tobacco use?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ I don't work outside the home

9. Are you confident that you will be able to stop using tobacco?

- ☐ Not confident at all
- ☐ Somewhat confident
- ☐ Very confident

10. Which stressors, if any, are you dealing with now?

_____

11. What is the biggest obstacke you face in stopping tobacco use?

_____

12. Second hand smoke:

Yes	No	D/K	
☐	☐	☐	Is tobacco use allowed inside your home? If yes, what type?_____
☐	☐	☐	Does anyone else in your home use tobacco?

13. Have you ever had any of the following?

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart disease
- ☐ Alcoholism
- ☐ Depression
- ☐ Numbness/cramping in arms or legs
- ☐ Frequent cough or chest colds
- ☐ Chest pain or tightness in the chest
- ☐ Morning cough or phlegm-producing cough
- ☐ Shortness of breath
- ☐ Emphysema/Lung disease
- ☐ Cancer; type_____
- ☐ Other:_____

14. How often do you consume alcohol?

- ☐ 0 - 2 drinks per week
- ☐ 3 - 5 drinks per week
- ☐ 6 or more drinks per week

15. Females only:

Yes	No	D/K	
☐	☐	☐	Are you pregnant?
☐	☐	☐	Are you planning to become pregnant?

Stage of Change

☐ Precontemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance

Refer for cessation counseling: ☐ Yes ☐ No Date:_____