


<p>General Practice Associates <i>Community General Hospital</i></p> <p style="text-align: center;">PROGRESS NOTES</p>  <p style="font-size: small;">001500 09960</p>	<p>MR# _____</p> <p>Enc. # _____</p> <p>Name _____</p>																				
COMPLETE OR IMPRINT WITH ADDRESS OF PAYER																					
<p>Tobacco use history:</p> <p>Current average daily tobacco use? <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> chew <input type="checkbox"/> pipe tobacco</p> <p>Largest amount of tobacco ever used regularly: _____ Total years using tobacco: _____</p> <p>Current Brand: _____ Menthol? _____</p> <p>Time to first cigarette in morning? <input type="checkbox"/> < 30 minutes <input type="checkbox"/> > 30 minutes</p> <p>Motivation to quit: <input type="checkbox"/> Health <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Money <input type="checkbox"/> Symptoms <input type="checkbox"/> Control of life <input type="checkbox"/> Appearance <input type="checkbox"/> Required at work <input type="checkbox"/> Other:</p> <p>"On a scale of 1 to 10, how confident are you that you will be tobacco-free in 6 months?" _____</p> <p>Past Attempts to Stop Smoking:</p> <p>Date of last attempt: _____ Number of previous attempts: _____</p> <p>Longest duration without smoking: _____ Relapse details: _____</p> <p>Previous methods: <input type="checkbox"/> "cold-turkey" <input type="checkbox"/> tapered down <input type="checkbox"/> self-help materials <input type="checkbox"/> group help program (Check any that apply) <input type="checkbox"/> individual counseling <input type="checkbox"/> hypnosis / acupuncture <input type="checkbox"/> NRT <input type="checkbox"/> Bupropion <input type="checkbox"/> Combination NRT (ex. patch & gum) used together on same day <input type="checkbox"/> Chantix <input type="checkbox"/> Combination NRT & Bupropion used together on same day</p> <p>Potential obstacles: <input type="checkbox"/> Severe cravings <input type="checkbox"/> Anxiety <input type="checkbox"/> Weight gain <input type="checkbox"/> Social pressure <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Irritability <input type="checkbox"/> Depression <input type="checkbox"/> Other:</p> <table style="width: 100%; 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BINDING MARGIN - DO NOT WRITE OR PRINT IN THIS AREA