ASSESSMENT OF TOBACCO USE AND EXPOSURE

Please complete this assessment tool even if you do not use tobacco. The information you provide to your physician will assist in the evaluation and management of your care and the care of your family members.

Date: ______________
Patient Name: ________________________________
Patient Date of Birth: ____________________

1. **I smoke cigarettes:**
   ___ Never
   ___ I quit (How long ago? ___ Number of years you smoked___ Cigarettes/day?___)
   ___ Occasionally (please complete the attached Fagerström Test for Nicotine Dependence)
   Explain ____________________________________
   ___ Daily (please complete the attached Fagerström Text for Nicotine Dependence)
   (Number of years you have smoked___ Cigarettes/day ___)

2. **I smoke cigarettes or a pipe, or use smokeless tobacco.**
   ___ No (If No, skip to question #11.)
   ___ Yes

3. **Do you wake up and smoke after going to bed for the night?**
   ___ No
   ___ Yes If yes, ____ nights per week/per month (circle one)

4. **How old were you when you started smoking?** _______

5. **For all of your smoking years, how many cigarettes per day did you average?** ________

6. **How many times have you seriously tried to stop smoking for more than 24 hours?** _______

7. **How did you try?** (list all the different ways) ____
   ____
   ____

8. **What is the longest period of time you were able to stop smoking?** _____________

9. **How did you stop that time?** ____
   ____
   ____

10. **Do you want to stop smoking within the next 2 to 3 weeks?**
    ___ No
    ___ Yes

11. **One or more members of my family use tobacco products in the home.**
    ___ No
    ___ Yes Explain ____
    ____

12. **One or more of my coworkers uses tobacco products at work.**
    ___ No
    ___ Yes Explain ____
    ____

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13. I am regularly exposed to tobacco products in another location.
    ___ No
    ___ Yes Explain ____
    ____

14. I have been diagnosed with asthma, COPD, or another respiratory disease.
    ___ No
    ___ Yes Explain ____
    ____

15. I have never been diagnosed with respiratory disease, but I have respiratory symptoms, such as coughing, wheezing, shortness of breath, etc.
    ___ No
    ___ Yes Explain ____
    ____

Please return this form to the receptionist or directly to your physician. Thank you!

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