


<p>Thomas Jefferson University Hospital <i>Jefferson Health System</i></p> <p style="text-align: center;">PROGRESS NOTES</p>  <p>001500 09960</p>	<p>MR# _____</p> <p>Enc. # _____</p> <p>Name _____</p>							
COMPLETE OR IMPRINT WITH ADDRESS OF PLANT								
<p><u>Tobacco use history:</u></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><u>Current Brand:</u> _____ <u>Menthol?</u> _____</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><u>Past Attempts to Stop Smoking:</u></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 (Zyban, Wellbutrin) <input type="checkbox"/> Combination NRT (ex. patch & gum) used together on same day <input type="checkbox"/> Varinicline <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> <p>Contraindications to Bupropion SR?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Absolute</u> <input type="checkbox"/> Seizure history <input type="checkbox"/> Eating disorder <input type="checkbox"/> Current MAO inhibitor <input type="checkbox"/> Other Bupropion products </td> <td style="width: 50%; vertical-align: top;"> <u>Relative</u> <input type="checkbox"/> Heavy alcohol use <input type="checkbox"/> Benzodiazapine use <input type="checkbox"/> Prior adverse reaction <input type="checkbox"/> Other antidepressants </td> </tr> </table> <p>Contraindications to NRT?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Relative</u> <input type="checkbox"/> Unstable hypertension <input type="checkbox"/> Serious arrhythmias <input type="checkbox"/> Hypersensitivity to adhesive </td> <td style="width: 50%;"></td> </tr> </table> <p><u>Plan for Care (include plan for follow-up):</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; 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BINDING MARGIN - DO NOT WRITE OR PRINT IN THIS AREA