Patient Information Questionnaire-Tobacco Cessation

Please put a check mark (✓) next to your answer. Add additional information where needed.

Question	Answer	
1. Which of the following **best** describes your **current** relationship status?	Partner in an Unmarried Couple	
	Currently Married	
	Divorced/Separated	
	Widowed	
	Single	
2a. Do you have any children?	YES how many?	
	NO	
2b. How many children are 18 years or younger?		
2c. How many children live with you?		
2d. What is your annual income from all sources?	☐ less than 10,000 ☐ 20,001-25,000 ☐ 35,001-40,000 ☐ 10,001-15,000 ☐ 25,001-30,000 ☐ 40,001- 45,000 ☐ 15,001-20,000 ☐ 30,001-35,000 ☐ more than 45,001	
3. What race/ethnicity describes you? (check all that apply)	American Indian/Alaska Native	
	Asian	
	Black or African American	
	Hispanic or Latino	
	Native Hawaiian or Pacific Islander	
	White	
	Other *please indicate:*	
4a. Which of these describe your current enrollment and/or employment status?	Full-time employment	
	Part-time employment	
	A full-time student	
	Part-time student	
	Retired	
	Disabled	
4b. What is your occupation (if applicable)?	Occupation:	
4c. Do people smoke outside the entrance/exit of your workplace?	YES	
	NO	

TOBACCO SPECIFIC INFORMATION TOBACCO USE HISTORY

5. Please check next to the appropriate type of tobacco:

Do you use:				
	Cigarettes:	___Currently	___Previously	___Never
	Spit Tobacco/Chew:	___Currently	___Previously	___Never
	Cigars or Pipe:	___Currently	___Previously	___Never
	Hookah	___Currently	___Previously	___Never

Question	
6. What age were you when you first used or tried tobacco?	
7a. What age were you when you started using tobacco on a regular basis?	
7b. How many years have you used tobacco?	

Last name, first name ____________________________

Student ID # ______________________________

8. How many cigarettes do you smoke each day?		
9. Give the full details of your main current cigarettes (brand, name, size, flavor etc):		
10. How many minutes after you wake up do you smoke your 1st cigarette?		
11a. Do you sometimes awaken at night to have a cigarette or use tobacco?	YES	
	NO	
11b. If yes, how many nights per week do you typically awaken to smoke?		
12. How many times have you tried to quit smoking?		

CURRENT QUIT ATTEMPT

14. How **important** is it to you to stop tobacco use now?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not at all — Average Importance — Extremely Important

15. How **confident** are you that you will succeed in stopping your tobacco use now?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not At All — Somewhat Confident — Extremely Confident

16. Do your friends and family smoke?
Please check one box.

1	2	3	4	5	6	7	8	9	10

None are Smokers — About Half are Smokers — All are Smokers

17. Are you around smokers much of the time?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Never — Sometimes — Always

Last name, first name ____________________ Student ID # ____________________

18. Which statement best describes smoking inside your primary residence?

a. Smoking is allowed anywhere inside.	
b. Smoking is allowed in some places or sometimes.	
c. Smoking is *not* allowed anywhere inside.	
d. Other *please indicate*	

19. Please check (✓) next to the **one statement that best describes** your current situation:

a.	I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get.	
b.	I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by 50%or more), but am not interested in quitting totally.	
c.	I am seriously considering quitting in the next 6 months, but not in the next 30 days.	
d.	I currently smoke/use tobacco and am certain that I do not want to quit in the next 6 months.	
e.	I have recently stopped smoking/using tobacco, and I need to work at not slipping back to using.	
f.	I have not smoked/used tobacco products for over 6 months.	

CURRENT HEALTH and MEDICAL HISTORY

20. Currently, do you have any symptoms or an illness that you believe is caused or made worse by your tobacco use?	YES	
	NO	
21. Have you ever received counseling, treatment or medication for mental, emotional or behavioral health?	YES	
	NO	
22. Have you ever received counseling, treatment or medication for alcohol or other drug use?	YES	
	NO	

Do you have a history of:	YES	NO
Seizures, convulsions or epilepsy		
Head trauma, brain damage or brain tumor		
Disordered eating (anorexia, bulimia)		
Depression		
Bipolar Disorder		
Schizophrenia		
Uncontrolled high blood pressure		
Kidney or liver disease		
Cancer, TYPE:		
Difficulty sleeping or insomnia		
Recent heart attack, angina, chest pain or abnormal heart rhythm		
Lung Disease (asthma, emphysema, COPD)		
Sinus or nasal problems		
Did you ever feel like you wanted to hurt yourself		
Are you currently on Wellbutrin or Zyban		
→If YES, Have you ever had an adverse reaction to Wellbutrin or Zyban		
Are you currently on a MAO Inhibitor (Nardil, Parnate)		
Are you currently on medications that could increase seizures		
Are you taking medication for diabetes		
Do you use stimulants, diet medications or caffeine (circle answer)		
Do you have a previous adverse reaction to nicotine replacement medications		
Females only: are you pregnant, breast feeding or planning pregnancy in the near future		

24. The following questions ask about how you have been feeling during the **past 4 weeks**. For each question, please circle the number that best describes how often you had this feeling.

In the last 4 weeks, about how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. **so** sad that nothing could cheer you up?	**4**	**3**	**2**	**1**	**0**
b. nervous?	**4**	**3**	**2**	**1**	**0**
c. restless or fidgety?	**4**	**3**	**2**	**1**	**0**
d. hopeless?	**4**	**3**	**2**	**1**	**0**
e. everything was an effort?	**4**	**3**	**2**	**1**	**0**
f. worthless?	**4**	**3**	**2**	**1**	**0**

In the **last 4 weeks**, how many times have you seen a health professional about these feelings?
Number of visits __________

Comments ____

25. Would you say that, in general, your health is:

Excellent	
Good	
Fair	
Poor	

Questionnaire adapted from New Jersey QuitCenters © 2006

Last name, first name ___________________________

Student ID # ___________________________