Tobacco Use Assessment Form

Name: _____ **Date:**_____

1. **Have you ever smoked cigarettes or used any other tobacco product?**
   ___ Yes
   ___ No

2. **Do you currently smoke cigarettes or use any other tobacco product?**
   ___ Yes
   ___ No -- Date Stopped _____

   If you answered yes to questions 1 or 2, please answer the following:
   Type of tobacco and brand name _____
   Length of use (in months or years) _____
   Amount used per day on average _____

3. **Does anyone you live with or who is close to you smoke cigarettes or use other forms of tobacco?**
   ___ Yes
   ___ No

(Continue only if you answered *Yes* to #2)

4. **How soon after you wake up do you smoke your first cigarette or use other forms of tobacco?**
   ___ Within 30 minutes
   ___ More than 30 minutes

5. **How interested are you in stopping smoking or stopping use of other forms of tobacco?**
   ___ Not at all
   ___ A little
   ___ Some
   ___ Very

6. **If you decided to quit smoking or using other forms of tobacco completely during the next 2 weeks, how confident are you that you would succeed?**
   ___ Not at all
   ___ A little
   ___ Some
   ___ Very

7. **Have you ever intentionally quit smoking/using other forms of tobacco for 24 hours or longer?**
   ___ Yes ___ No

   In the past year? ___ Yes ___ No
   In the past month? ___ Yes ___ No
   Since the last visit? ___ Yes ___ No

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