

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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