

Tobacco Use Assessment

1. How soon after you wake up do you have your first cigarette?
 - Within 5 minutes
 - 6-30 minutes
 - 31-60 minutes
 - After 60 minutes
2. How many cigarettes (or other tobacco product) per day do you smoke (or use)? _____
3. In a typical week, how many nights do you wake up and use tobacco? _____
4. Please check which kinds of tobacco you use now: Cigarettes Pipe Hookahs Cigars Blunts
 Little cigars Chew, Spit or SNUS Bidis E-cigarette/Vaping device Other _____
5. How frequently do you use any tobacco products checked above? _____
6. How old were you when you first tried tobacco? _____
7. How many other tobacco users live with you? _____
8. What was the longest amount of time you were able to go without smoking or using tobacco? _____
When was that? _____
9. When was the last time you tried to quit smoking or using tobacco? _____
10. What tobacco treatment medications have you used in the past to stop smoking or using tobacco?

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Nicotine patches | <input type="checkbox"/> Bupropion (also called Zyban or Wellbutrin) |
| <input type="checkbox"/> Nicotine gum | <input type="checkbox"/> Varenicline (Chantix) |
| <input type="checkbox"/> Nicotine lozenge | <input type="checkbox"/> Combination of any of these medications (ex: Patch + Lozenge) |
| <input type="checkbox"/> Nicotine inhaler | <input type="checkbox"/> Other medication _____ |
| <input type="checkbox"/> Nicotine spray | |

11. If you have quit before, what things triggered you to return to smoking or using tobacco?

Please check all that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Boredom | <input type="checkbox"/> Social situations |
| <input type="checkbox"/> Withdrawal symptoms | <input type="checkbox"/> Being around other smokers | <input type="checkbox"/> Weight problems |
| <input type="checkbox"/> Urges to smoke or use | <input type="checkbox"/> Drinking alcohol | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> A crisis | <input type="checkbox"/> Other _____ | |

12. On a typical day, how many caffeinated beverages do you drink (coffee, tea, colas, energy drinks)? _____

[Questions 14-17 are best asked as part of a tobacco counseling conversation]

13a. On a scale of 0-10 how interested are you to quit tobacco? ____

13b. On a scale of 0-10 how confident are you that if you tried to quit, you could succeed? ____

14. What things do you like or value about your tobacco use? _____

15. What reasons do you have now for wanting to quit? _____

16. What worries or concerns do you have about quitting? _____

17. Please list any spiritual or cultural issues that are important to your tobacco use: _____