

# Tobacco Use Questionnaire



Your Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Best time to contact you: \_\_\_\_\_ (am pm) Best # to contact you:  Home #  Work #  Cell # Is it Okay to leave a message?  Yes  No

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female Race:  Alaska Native  Native American  Caucasian  Other

Name of provider: \_\_\_\_\_

Number of tobacco users in your home: \_\_\_\_\_

Please circle the highest school grade you have completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

What is your work status? Unemployed Retired Disabled Full time Part time Housewife or Househusband

Please tell us about the types of tobacco you use by filling out the table:

	Cigarettes	Chew (Like Copenhagen)	Tobacco & Ash	Pipe	Cigar
Have you ever used this product?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How much tobacco do you <u>currently</u> use?	_____cigarette a day	_____cans per week _____chew per/day	_____cans per/ week _____chew per/day mix in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	_____times a day	_____times a day
How many years used?	_____years	_____years	_____years	_____years	_____years

1. Are you planning to stop using tobacco? (Please check only one)

- a.  Yes, I've already stopped
- b.  Yes, plan to stop today
- c.  Yes, in the next 30 days.
- d.  Yes, within the next 6 months.
- e.  Not sure
- f.  No, I'm not planning to stop for good

Are you currently pregnant?  No  Yes If Yes, Please complete the following questions...

1. When is your baby due: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Why are you seeing a Nicotine Dependence Treatment Counselor? (Check all that apply)

- I wanted to talk to someone about tobacco use
- My provider referred me to the Nicotine Dependence Treatment Program
- My family wanted me to join the Nicotine Dependence Treatment Program
- Uncertain

3. What is your main concern about using tobacco during your pregnancy?

- I am concerned that my baby will be born too early
- I am concerned that my baby may be addicted to tobacco
- I am concerned my baby will be underweight
- I am concerned about having an unhealthy baby
- I do not have any concern

4. After learning you were pregnant, have you changed the type of tobacco you use?

- Yes, I switched from cigarettes to commercial chew
- Yes, I switched from cigarettes to Ash mixed with Tobacco (Iqmik, Blackbull, or Dediguss)
- Yes, I switched from commercial chew to Ash mixed with Tobacco (Iqmik, Blackbull, or Dediguss)
- Yes, I switched from chew to cigarettes
- No, I did not make any changes in the type of tobacco I use

5. After learning you were pregnant, did you change how much tobacco you use?

- Yes, I **increased** how many cigarettes or chews per day I use
- Yes, I **decreased** how many cigarettes or chews per day I use
- Yes, I **quit** using tobacco
- Yes, I am **trying to quit** tobacco
- No, I did not make any changes in how much tobacco I use

6. What kind of information would you like about tobacco use? (Check all that apply)

- Tobacco use and Pregnancy
- Tobacco use and Children
- Tobacco use and Breast Feeding
- General Information about Tobacco Addiction
- I do not want any information

7. How would you like to receive this information? (Check all that apply)

- Brochures
- Meet with a Nicotine Dependence Treatment Counselor
- Video
- Phone Call
- I do not want to receive any information

8. Have you had other pregnancies?

- Yes  No If yes, did you use tobacco during the pregnancy?  Yes  No

Name:  
Chart #:  
DOB:

Counselor Signature:

Date:

**2. Have you ever had or currently have any of the following? (Check all that apply)**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Peptic Ulcer Disease            | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Mouth Sores         |
| <input type="checkbox"/> Head injury        | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Coronary artery disease     | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Eating disorders   | <input type="checkbox"/> Skin allergy or sensitivities   | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Alcohol withdrawal | <input type="checkbox"/> Emphysema or chronic bronchitis | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> High blood pressure |
|   |  |  | <input type="checkbox"/> Cough               |

**3. Do you have a history of depression?**  Yes  No

**4. Do you have a history of anxiety?**  Yes  No

**5. Have you ever used alcohol?**  Yes  No

**If Yes:** Do you currently use Alcohol?  Yes  No

How many drinks per week on average do you have?

# Drinks \_\_\_\_\_ a **week** (one drink = one beer, one glass of wine, one shot alcohol)

**6. Have you received treatment for alcohol or other drug dependency?**  Yes  No

**If Yes:** Are you currently receiving treatment for this condition?  Yes  No

Have you been sober and/or drug free for a year or more?  Yes  No

**7. Have you tried to stop using tobacco before today?**  Yes   No...if "No" please go to question # 8

**How many times have you tried to stop using tobacco?**  1  2  3  4  5 or more times

**What is the longest you have gone without using tobacco?** \_\_\_\_\_ (days, weeks, months, or years)

**Which of these symptoms have you had when you've tried to stop using tobacco? (Check all that apply)**

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Cravings for tobacco     | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Eating more      |
| <input type="checkbox"/> Trouble concentrating    | <input type="checkbox"/> Depression    | <input type="checkbox"/> Frustration  | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Grouchiness/irritability | <input type="checkbox"/> None of these | <input type="checkbox"/> Other: _____ |   |

**When was the last time you tried to stop using tobacco?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Less than 1 month ago | <input type="checkbox"/> 7 to 12 months ago      | <input type="checkbox"/> More than 5 years ago  |
| <input type="checkbox"/> 1 to 6 months ago     | <input type="checkbox"/> More than 12 months ago | <input type="checkbox"/> More than 10 years ago |

**What made you start again?** \_\_\_\_\_

**How have you tried to stop in the past? (Check all that apply)**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Nicotine gum            | <input type="checkbox"/> Nicotine patch    | <input type="checkbox"/> Quitting "cold turkey" | <input type="checkbox"/> Cutting down gradually |
| <input type="checkbox"/> Zyban/ Wellbutrin pills | <input type="checkbox"/> Nicotine lozenge  | <input type="checkbox"/> Individual counseling  | <input type="checkbox"/> Group counseling       |
| <input type="checkbox"/> Nicotine inhaler        | <input type="checkbox"/> Hypnosis          | <input type="checkbox"/> Being in jail          | <input type="checkbox"/> Nicotine Nasal Spray   |
| <input type="checkbox"/> Being in the hospital   | <input type="checkbox"/> Herbs: Type _____ |   | <input type="checkbox"/> Acupuncture            |
|  |  |   | <input type="checkbox"/> Other: _____           |

**If you used a nicotine replacement or Zyban, did you have side effects?**  Yes  No

**If yes, what product(s) and what side effect(s)?** \_\_\_\_\_

**8. What is your main reason for wanting to stop using tobacco? (Check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Health Reasons | <input type="checkbox"/> To Save Money                | <input type="checkbox"/> To be a Positive Role Model |
| <input type="checkbox"/> Live Longer    | <input type="checkbox"/> Protect the health of others | <input type="checkbox"/> Other (s): _____            |

**9. When do you use tobacco? (Check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> When feeling stressed | <input type="checkbox"/> When wanting to cheer up | <input type="checkbox"/> When drinking coffee, tea or soda    |
| <input type="checkbox"/> When feeling anxious  | <input type="checkbox"/> When bored               | <input type="checkbox"/> When wanting something in your mouth |
| <input type="checkbox"/> After meals           | <input type="checkbox"/> When At work             | <input type="checkbox"/> When hunting or fishing              |
| <input type="checkbox"/> When relaxing         | <input type="checkbox"/> When drinking            | <input type="checkbox"/> When around other users              |

**10. Does anyone in your family have a tobacco-related disease?**  No  Yes, what disease(s) \_\_\_\_\_

**11. What is the biggest obstacle you face in stopping tobacco use?** \_\_\_\_\_

**12. Are you under a lot of stress now?**  Yes  No

**If yes, from what?** \_\_\_\_\_

**13. Where did you hear about our program?** \_\_\_\_\_

Name:  
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**14. If you smoke cigarettes:**



**How soon after you wake up do you smoke your first cigarette?**

- Within 5 minutes<sup>3</sup>
- 6 to 30 minutes<sup>2</sup>
- 31 to 60 minutes<sup>1</sup>
- After 60 minutes<sup>0</sup>

**Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in public buildings?**

- Yes<sup>1</sup>
- No<sup>0</sup>

**Which cigarette would you hate most to give up?**

- The first one in the morning<sup>1</sup>
- Any other<sup>0</sup>

**How many cigarettes per day do you smoke?**

- Less than 10<sup>0</sup>
- 11 to 20<sup>1</sup>
- 21 to 30<sup>2</sup>
- More than 31<sup>3</sup>

**Do you smoke more frequently during the first hours after waking than during the rest of the day?**

- Yes<sup>1</sup>
- No<sup>0</sup>

**Do you smoke if you are so ill that you are in bed most of the day?**

- Yes<sup>1</sup>
- No<sup>0</sup>

**15. If you chew or use ash mixed with tobacco:**



**How soon after you wake up do you put in your first chew/ash mixed with tobacco?**

- Within 5 minutes<sup>3</sup>
- 6 to 30 minutes<sup>2</sup>
- 31 to 60 minutes<sup>1</sup>
- After 60 minutes<sup>0</sup>

**Do you intentionally swallow tobacco juices?**

- Never<sup>0</sup>
- Sometimes<sup>1</sup>
- Always<sup>2</sup>

**Which chew/ash mixed with tobacco would you hate most to give up?**

- The first one in the morning<sup>1</sup>
- Any other<sup>0</sup>

**How many cans of chew/ash mixed with tobacco do you use a week?**

- More than 3<sup>3</sup>
- 2 – 3<sup>2</sup>
- 1 – 2<sup>1</sup>
- Less than 1<sup>0</sup>

**Do you chew more frequently during the first hours after waking than during the rest of the day?**

- Yes<sup>1</sup>
- No<sup>0</sup>

**Do you use chew when you are so ill that you are in bed most of the day?**

- Yes<sup>1</sup>
- No<sup>0</sup>

**Please give this questionnaire to the counselor**

*(This area is to be completed by the Counselor)*

**I =**

**C =**

Chart # \_\_\_\_\_  Self Referral  Provider Referral  Specialty Clinic \_\_\_\_\_  
 Other \_\_\_\_\_

Target Quit Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Readiness Level:  Pre-contemplator (>6mo)  Contemplator (1-6mo)  Preparation (<1mo)  Action (qt1-6mo)  Maintenance (qt 6mo+)

Fagerstrom score: \_\_\_\_\_ **SMOKE**      \_\_\_\_\_ **CHEW/IQMIK**      Counselor: \_\_\_\_\_      CO level: \_\_\_\_\_

(< 4 = nicotine dependent; > 6 = highly nicotine dependent)

Employer:  ANTHC  SCF  Other \_\_\_\_\_      Type of Employee:  Beneficiary  Non-Beneficiary

Employment Classifications:  Direct Hire  Commissioned Corp  Civil Services

Employment Type:  Regular Full-Time  Regular Part-Time  Part Time  Temporary  Intermittent

Name:

Chart #:

DOB:

Counselor Signature:

Date: