State Wellness Center
101 S. Union Street
Montgomery, AL 36104
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Tobacco Cessation Program

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Primary Insurance Contract Number:	**Primary Insurance Group Number:**		
Secondary Insurance Contract Number:	**Secondary Insurance Group Number:**		
Address:	**Pharmacy:**	**Primary Physician:**	
Specialist Physician Name And Specialty:	**Specialist Physician Name And Specialty:**		
Emergency Contact:	**Phone Number:** **Relation:**		

Why do you wish to quit tobacco usage?

_____

Tobacco Usage:

- At what age did you begin using tobacco? _____
- How many years have you used tobacco products? _____
- What type of tobacco do you use? _____
- How often do you use tobacco? _____
- Have you used tobacco more or less than you do now? If so, please quantify (example: 2 packs per day for 10 years and then 1 pack per day for 5 years) _____
- Have you ever attempted to quit tobacco? _____
    - How many quit attempts have you made? _____
    - When was your first attempt to quit tobacco? _____
        - What method did you use for this quit attempt? (cold turkey, nicotine patch, etc.) _____
    - When was your last attempt to quit tobacco? _____
        - What method did you use for this quit attempt? _____

- What other tobacco cessation methods have you tried? _____
    - What tobacco cessation methods were effective? _____
    - How long did you quit tobacco after using this (these) method(s)? _____
    - What triggered you to start tobacco again? _____
    - What tobacco cessation methods were ineffective? _____

Have you ever used any pharmacotherapy (nicotine replacement therapy or bupropion)? _____

Reasons for Tobacco Usage:

- Why did you first begin tobacco? _____
- What do you enjoy most about tobacco? _____
- Are there situations which cause you to use tobacco more? _____
    - If so, what are they? _____
    - Are they stress-related? _____
- Do you experience anxiety, moodiness, or other withdrawal symptoms when trying to quit tobacco? _____

If so, please rate the severity of your withdrawal symptoms using a scale of 1= least severe to 10= most severe:

Symptom 1: _____ Severity Rating: _____

Symptom 2: _____ Severity Rating: _____

Symptom 3: _____ Severity Rating: _____

Tobacco Patterns:

- Where do you use tobacco products? _____
- Does your job make it easier or more difficult to use tobacco products? _____
    - Do you take tobacco breaks? _____ If so, how many per work day? _____
- What time of the day do you use tobacco the most? _____
- Do you drink alcohol? _____
    - If so, what kind, how much, and how often? _____
    - Do you use tobacco more when you drink alcohol? _____
- Is there anything that you are currently doing to lower your tobacco use? (examples: gum, hard candy, etc.) _____

Motivation:

- When do you think you could quit tobacco? (today, next week, < 6 months, >6 months) _____
- How confident are you that you can quit tobacco and stay quit for 1 year or more? (Highly confident, Somewhat confident, Unsure) _____
- Do you anticipate any barriers to tobacco cessation? _____

Diet and Exercise:

- Is weight gain as a result of tobacco cessation a concern for you? _____
- Do you currently exercise? _____
    - If so what type of activity do you engage in? _____
- How many times per week do you exercise? _____ For how long each time? _____
- Does tobacco interfere with any exercise activities that you enjoy? _____
- What other barriers to exercise do you experience? _____

Past Medical History:

- List your past surgeries: _____

_____

Medical History Update (check all that apply):

☐ Allergic Rhinitis (Hayfever)	☐ Liver Problems
☐ Asthma	☐ Low Bone Density (Osteoporosis)
☐ Chronic Bronchitis	☐ Lung Cancer
☐ Depression	☐ Other Cancer Type:_____
☐ Diabetes	☐ Overweight/Obesity
☐ Emphysema	☐ Seizures
☐ Heart Problems (AMI, CAD, CHF)	☐ Sexual Problems (ED)
☐ Heartburn	☐ Sinusitis
☐ High Blood Pressure	☐ Skin Allergies(Eczema)
☐ High Cholesterol	☐ Stomach Ulcers
☐ High Triglycerides	☐ Stroke
☐ Infertility/Miscarriage/Low Birth Weight	☐ Thyroid Disease
☐ Kidney Problems	
☐ Other:	

Social History:

- Does anyone in your home or work environments use tobacco? _____
- Is Tobacco allowed in your work environment? _____
- Do you ingest caffeine? (Coffee, Tea, Colas, Chocolate, etc.) _____
- Do you use recreational drugs (marijuana, cocaine, etc.)? _____
- Do you have a support network of family or friends who will assist you / support you with your quit attempt? _____

Medications (Please list all prescription and over the counter medications):

Medication Name	**Dose (milligrams, units, etc.)**	**When do you take it?** (time of day)	**When did you start taking this medication?**	**What is this medication for?**