Smoking Assessment Form

Date_____ Name_____

1. Do you now smoke cigarettes?
   _____ yes _____no

2. Does the person closest to you smoke cigarettes?
   _____ yes _____no

3. How many cigarettes do you smoke a day? _____ cigarettes

4. How soon after you wake up do you smoke your first cigarette?
   _____ within 30 minuntes _____more than 30 minutes

5. How interested are you in stopping smoking?
   _____not at all _____a little _____some _____a lot _____very

6. If you decide to quit smoking completely during the next 2 weeks, how confident are you that you would succeed?
   _____not at all _____a little _____some _____a lot _____very

For Physicians Only

Visit Date:

Quit Date (Y/N):

Follow-up Date & Comments:

How to Help Your Patients Stop Smoking, A National Cancer Institute Manual for Physicians
T. Glynn, Ph.D., M. Manley, M.D., M.P.H.

US Dept. of Health and Human Services, Public Health Service, NIH