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 minutes ☐ more than 30 minutes

5. How interested are you in stopping smoking?

☐ not at all ☐ a little ☐ some ☐ a lot ☐ very

6. If you decided 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 Yes	Quit Date No	When	Date of Followup Visit	Comments

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