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 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
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