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)	When	Followup 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 Humna Services, Public Health Service, NIH