### TOBACCO USE HISTORY

#### SELF-ASSESSMENT

1. **Check the box that best describes you:**
   - A. I am using tobacco and have not thought about quitting. *(Pre-contemplation)*
   - B. I am using tobacco and have just started thinking about quitting. *(Contemplation)*
   - C. I am using tobacco and am preparing to quit. *(Preparation)*
   - D. I quit using tobacco less than 3 weeks ago. *(Action)*
   - E. I quit using tobacco 3 or more weeks ago. *(Maintenance)*

2. **How old were you when you first began to smoke?**

3. **In the past year, which of the following tobacco products have you used?**
   - Cigarettes
   - Cigars
   - Pipe
   - Dip/chew
   - Other *(Please specify.)*

4. **On average, how many days in the past month have you used tobacco?**

5. **When you used any of the following, how much did you usually use?**
   - Cigarettes **###** # of cigarettes per day *(20 cigarettes = 1 pack)*
   - Cigars **###** # per day
   - Dip/Chew **###** # of dips per day
   - Pipe **###** # of bowls per day

6. **How many years have you used tobacco?**

7. **Have you ever tried to quit using tobacco?**
   - Yes
   - No
   - **If yes, how many times?**
     - a. **What methods have you tried?** *(Check all that apply.)*
       - On my own
       - Oral inhaler
       - Nicorette gum
       - Zyban/Wellbutrin
       - Nicotine patch
       - Web site for smoking cessation
       - Nasal spray
       - Other *(Please specify.)*
   - b. **What is the longest period of time you stayed away from cigarettes since you started smoking?**
     - **What was your greatest obstacle to quitting?**

8. **Which of the following people in your life currently use tobacco?** *(Check all that apply.)*
   - Close friends
   - Significant Other
   - Parent(s)
   - Sibling(s)
   - Roommate(s)
   - Co-worker(s)

9. **Have you experienced any of the following in the past year?**
   - Bronchitis
   - Shortness of breath with exertion
   - Asthma
   - Persistent cough
   - Sinus Infection
   - Persistent hoarseness
   - Ear Infection
   - Sores in your mouth/lips
   - Other long-term illness
   - Other respiratory condition
   - Allergies
   - Heartburn

10. **Would you like information about tobacco cessation?**
    - I am not interested at this time.
    - I would like to talk with my primary care provider about quitting. **Call UHS at 275-2662 to schedule an appointment.**
    - I would like to speak with a nurse by telephone. **Call UHS at 275-1160 to speak with a nurse.**
    - I would like information about quitting. **Check the list of resources listed on the back of this sheet.**
### How Dependent On Nicotine Are You?

A. Do you often find yourself smoking a cigarette when you were not aware of lighting one up?  
B. Do you associate your smoking with other actions such as having an alcoholic beverage or talking on the phone?  
C. Do you sometimes forget to smoke all day?  
D. Do you smoke more after having an argument with someone?  
E. Is smoking one of the greatest pleasures in your life?  
F. Does the thought of never again smoking make you feel sad?  

<table>
<thead>
<tr>
<th></th>
<th>☑ Yes</th>
<th>☐ No</th>
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<tbody>
<tr>
<td>A</td>
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<td>F</td>
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</tbody>
</table>

Circle your response. Write the points in the SCORE column & total.

<table>
<thead>
<tr>
<th></th>
<th>A = 0 Points</th>
<th>B = 1 Point</th>
<th>C = 2 Points</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How soon after you wake do you smoke your first cigarette?</td>
<td>After 30 minutes</td>
<td>Within 30 minutes</td>
<td>NO POINTS</td>
</tr>
<tr>
<td>2</td>
<td>Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theater, doctor’s office?</td>
<td>No</td>
<td>Yes</td>
<td>NO POINTS</td>
</tr>
<tr>
<td>3</td>
<td>Which of all the cigarettes you smoke in a day is the most satisfying?</td>
<td>Any other than the first one in the morning.</td>
<td>The first one in the morning.</td>
<td>NO POINTS</td>
</tr>
<tr>
<td>4</td>
<td>How many cigarettes a day do you smoke?</td>
<td>1-15</td>
<td>16-25</td>
<td>More than 25</td>
</tr>
<tr>
<td>5</td>
<td>Do you smoke more during the morning than during the rest of the day?</td>
<td>No</td>
<td>Yes</td>
<td>NO POINTS</td>
</tr>
<tr>
<td>6</td>
<td>Do you smoke when you are ill (i.e., you are in bed most of the day)?</td>
<td>No</td>
<td>Yes</td>
<td>NO POINTS</td>
</tr>
<tr>
<td>7</td>
<td>Does the brand you smoke have a low, medium, or high nicotine content?</td>
<td>Low 0.4 mg</td>
<td>Medium 0.5 to 0.9 mg</td>
<td>High 1.0 mg</td>
</tr>
<tr>
<td>8</td>
<td>How often do you inhale the smoke from your cigarette?</td>
<td>Never</td>
<td>Sometimes</td>
<td>Always</td>
</tr>
</tbody>
</table>

A score of 4 points or more suggests you are dependent on nicotine. Want to quit? Talk with your primary care provider at UHS about quitting.

### Resources

- **University Health Service**  
  [www.rochester.edu/uhs](http://www.rochester.edu/uhs)  
  275-2662
- **University Counseling Center**  
  [www.rochester.edu/ucc](http://www.rochester.edu/ucc)  
  275-2361 or 275-3113
- **New York State Smokers’ Quitline**  
  [www.nysmokefree.com](http://www.nysmokefree.com)  
  1-888-609-6292
- **Centers for Disease Control and Prevention**  
  [www.cdc.gov/tobacco/how2quit.htm](http://www.cdc.gov/tobacco/how2quit.htm)
- **American Lung Association**  
  Quit Smoking Action Plan  
  [www.lungusa.org/partner/quit/](http://www.lungusa.org/partner/quit/)
- **American Lung Association**  
  Freedom From Smoking Online  
  [www.ffsonline.org](http://www.ffsonline.org)
- **American Cancer Society**  
  [www.cancer.org](http://www.cancer.org)  
  1-800-ACS-2345