

**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? _____ days

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? _____ years

7. Have you ever tried to quit using tobacco? Yes No

a. If yes, how many times? _____

b. 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.*)

c. What is the longest period of time you stayed away from cigarettes since you started smoking? _____

d. 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 Roommate(s)
- Parent(s) Sibling(s) Co-worker(s)

9. Have you experienced any of the following in the past year?

- Bronchitis Shortness of breath with exertion Other long-term illness
- Asthma Persistent cough Other respiratory condition
- Sinus Infection Persistent hoarseness Allergies
- Ear Infection Sores in your mouth/lips 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
B.	Do you associate your smoking with other actions such as having an alcoholic beverage or talking on the phone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
C.	Do you sometimes forget to smoke all day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
D.	Do you smoke more after having an argument with someone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
E.	Is smoking one of the greatest pleasures in your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
F.	Does the thought of never again smoking make you feel sad?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Circle your response. Write the points in the SCORE column & total.		A = 0 Points	B = 1 Point	C = 2 Points	SCORE
1	How soon after you wake do you smoke your first cigarette?	After 30 minutes	Within 30 minutes	NO POINTS	
2	Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theater, doctor's office?	No	Yes	NO POINTS	
3	Which of all the cigarettes you smoke in a day is the most satisfying?	Any other than the first one in the morning.	The first one in the morning.	NO POINTS	
4	How many cigarettes a day do you smoke?	1-15	16-25	More than 25	
5	Do you smoke more during the morning than during the rest of the day?	No	Yes	NO POINTS	
6	Do you smoke when you are ill (i.e., you are in bed most of the day)?	No	Yes	NO POINTS	
7	Does the brand you smoke have a low, medium, or high nicotine content?	Low 0.4 mg	Medium 0.5 to 0.9 mg	High 1.0 mg	
8	How often do you inhale the smoke from your cigarette?	Never	Sometimes	Always	
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.				TOTAL →	

RESOURCES

University Health Service
www.rochester.edu/uhs
 275-2662

University Counseling Center
www.rochester.edu/ucc
 275-2361 or 275-3113

New York State Smokers' Quitline
www.nysmokefree.com
 1-888-609-6292

www.gottaquit.com

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/how2quit.htm

American Lung Association
 Quit Smoking Action Plan
www.lungusa.org/partner/quit/

American Lung Association
 Freedom From Smoking Online
www.ffsonline.org

American Cancer Society
www.cancer.org
 1-800-ACS-2345