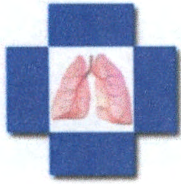
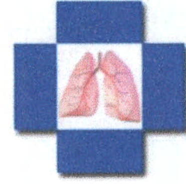


PULMONARY AND CRITICAL CARE SPECIALISTS
of NORTHERN VIRGINIA, P.C.



TOBACCO USE CESSATION COUNSELING
INITIAL ASSESSMENT

PATIENT: ______________________________________ **DATE:** _____/_____/_________
(Last Name) (First Name)

Do you currently smoke or use any type of tobacco product? ❑ **YES** ❑ **NO**
Have you ever smoked or used any type of tobacco product in the past? ❑ **YES** ❑ **NO**

IF YOU ANSWERED "NO" TO THE ABOVE QUESTIONS, YOU DO NOT NEED TO CONTINUE COMPLETION OF THIS FORM. IF YOU ANSWERED "YES" TO THE EITHER QUESTION, PLEASE CONTINUE.

What forms of tobacco do (did) you use? (Cigarettes, cigars, pipe, chewing tobacco, loose leaf tobacco, other) – please list below:

____

____

On a daily basis, how often or how much tobacco do (did) you use? __________________

Are you interested in receiving counseling and treatment options from your physician for tobacco use cessation (quitting)? ❑ **YES** ❑ **NO**

IF YES, THEN PLEASE ANSWER THE REMAINING QUESTIONS.

Have you tried to quit using tobacco in the past? ____________________________

What methods of quitting have you tried? ___________________________________

____

Why do you feel you have been unable to quit? ______________________________

____

PATIENT STOP HERE

Physician's suggestions:

❑ **Nicotine Replacement Therapy** ❑ **Zyban/Wellbutrin** ❑ **Chantix**
❑ **Behavior Modification** ❑ **Situational Avoidance** ❑ **Oral Substitution**
❑ **Other** ____

Return for follow up: ____

Physician Signature: ____________________________ **DATE:** ______/______/_________

NOTE: Please print and bring to your appointment.