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

TOBACCO USE CESSATION COUNSELING
FOLLOW UP ASSESSMENT

PATIENT: _____ **DATE:** ____/____/_____
(Last Name) (First Name)

Are you still continuing to smoke or use any type of tobacco product? ☐ **YES** ☐ **NO**

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

Do you feel you have been able to decrease your tobacco use? _____

On a daily basis, how often or how much tobacco do you use? _____

Which method(s) have been the most helpful in decreasing your tobacco use? _____

_____

What do you feel is still your biggest deterrent for quitting? _____

_____

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.