community health centers

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Tobacco Control Questionnaire

****Must be completed for all patients age 13 and above****

Patient Name: ________________________________ **Patient Gender:** M ☐ F ☐

Patient DOB: _________________________________ **Today's Date:** ______________

1. **Are you a?**
   - ☐ Current Smoker
   - ☐ Former Smoker
   - ☐ Never smoked
2. **If 'current smoker': How often do you smoke cigarettes?**
   - ☐ Every Day
   - ☐ Some days, but not every day
3. **If 'current smoker': How many cigarettes a day do you smoke?**
   - ☐ 5 or less
   - ☐ 6 - 10
   - ☐ 11 - 20
   - ☐ 21 - 30
   - ☐ 31 or more
4. **If 'current smoker': How soon after you wake up do you smoke your first cigarette?**
   - ☐ Within 5 minutes
   - ☐ 6 – 30 minutes
   - ☐ 31 – 60 minutes
   - ☐ After 60 minutes
5. **If 'current smoker': Are you interested in quiting?**
   - ☐ Ready to quit
   - ☐ Thinking about quiting
   - ☐ Not ready to quit

****Please present completed questionnaire to your provider's clinical assistant at your appointment****