

OHSU Tobacco Cessation Program Patient/Client Assessment

Name: _____

Today's Date: _____

Groupwise username/email address: _____

Date of Birth: _____

BACKGROUND

1. OHSU Status:

- | | |
|--|---|
| <input type="checkbox"/> Employee with benefits | <input type="checkbox"/> Employee without benefits |
| <input type="checkbox"/> Family member with benefits | <input type="checkbox"/> Family member without benefits |
| <input type="checkbox"/> Contract employee | <input type="checkbox"/> volunteer |
| <input type="checkbox"/> Student with benefits | <input type="checkbox"/> Student without benefits |

2. For employees: Please check one of the following job classifications:

- | | |
|---|--|
| <input type="checkbox"/> AFSCME represented | <input type="checkbox"/> Researcher (non-faculty) |
| <input type="checkbox"/> Faculty | <input type="checkbox"/> Student |
| <input type="checkbox"/> ONA represented | <input type="checkbox"/> Unclassified administrative |
| <input type="checkbox"/> Other | |

3. Male Female

TOBACCO USE HISTORY

4. Do you smoke cigarettes?

Yes less than 10 per day 10-20 per day more than 20 per day # per day
 No

5. Do you smoke cigars or pipes?

Yes Average number of cigars/pipes smoked per day in the last month: _____
 No

6. Do you use smokeless tobacco?

Yes less than 1 tin/pouch per day 1 tin/pouch per day more than 1 tin/pouch per day
 No Brand: _____

7. Have you ever quit using tobacco for 48 hours (2 days) or more on purpose? (Being sick or in the hospital does not count)

Yes How many times? _____
 No (**go to question # 10**)

8: What was the longest time you quit using tobacco?

Days: _____ OR Months: _____ OR Years: _____

9. Please check (✓) all the methods you have ever used to quit using tobacco. Complete all information for each method you check.

✓	Method	How many times?	Most recent time?	Able to quit at least 4 weeks?	Side effects (please describe, if any)
	Cold turkey (no drugs or assistance)				
	Individual Counseling or coaching (no medication)				
	Individual Counseling or coaching (with medication)				
	A stop smoking class or group				
	Telephone quit line				
	Internet stop smoking program				
	Nicotine gum				
	Nicotine lozenges				
	Nicotine nasal spray				
	Nicotine inhaler				
	Zyban® or Wellbutrin®				
	Varenicline (Chantix®)				
	Personal spiritual practice or prayer (specifically to help you quit tobacco)				
	Acupuncture				
	Hypnosis				
	Other (describe)				

10. Does anyone in your home smoke or use tobacco presently?

___ Yes ___ Spouse/Partner ___ Child ___ Friend ___ Other family member
___ No

11 Please circle the number that best describes how **ready you are to quit smoking or chewing**.

(Not ready) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extremely ready)

12. Please circle the number that best describes **how confident you feel about quitting**.

(No confidence) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Totally confident)

13. Please circle the number that best describes how **concerned or worried you are about gaining weight if you quit smoking or chewing?**

(No concern) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Highest concern)

14. Studies have shown that you have a better chance of quitting successfully if you have coaching and other support combined with medication.

Are you interested in using one of the stop smoking medications? ___ YES ___ NO (skip to Q.17)

Are you interested in finding out more about the options for coaching and support offered at OHSU?

___ YES ___ NO

Health History

15. Do you have a history of any of the following? (Please check (✓) all that apply)
- a. Significant drug allergies or drug reactions? (Please describe: _____)
 - b. Heart attack or treatment for cardiovascular disease within the past six weeks?
 - c. Allergy to any adhesives (tape, bandages, nicotine patch, etc)?
 - d. Head trauma requiring overnight stay in hospital?
 - e. Stroke, brain surgery, or brain tumor?
 - f. Seizures?
 - g. Anorexia or bulimia?
 - h. High blood pressure (hypertension)? If yes, is it controlled? Yes No
 Has there been a change in treatment in the last 6 weeks?
 - i. Liver disease?
 - j. Kidney disease?
 - k. Diabetes? If yes, do you take insulin? Yes No
 - l. Nerve disease or disorder?
 - m. Digestion problems or disorder such as gastritis or ulcers?
 - n. Hepatitis?
 - o. Lung disease such as chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis or asthma?
 - p. Shortness of breath when walking at a moderate pace or when walking upstairs?
 - q. Chronic cough?
 - r. History of cancer? (List here) _____
 - s. Currently drink alcohol?
s.1 If checked, have you or your family felt that you've had problems with alcohol? Yes No

For women:

- t. Are you pregnant, breast-feeding or trying to become pregnant?
- u. Are you taking birth control medication (e.g. pills, patch, cervical ring?)

16. Are you currently being treated or followed by a medical provider for any condition?
No Yes (please specify _____)

17. Sometimes your mood can interfere with smoking cessation. Have you had any of the following:
- a. Feeling down or sad most days for the last two weeks (or longer)?
 - b. Treatment for depression within the last six months?
 - c. Panic disorder, bipolar disorder or psychosis?
 - d. Post traumatic stress disorder?

18. Some medications interfere with smoking cessation medications. Please list all the prescription and non-prescription medications you are currently taking, and any herbal preparations:

19. For safety reasons, if a prescription medication is prescribed through OHSU a letter with the prescription information will be sent to your personal health care provider to be included in your medical chart. Please provide the name and address of your personal health care provider.

<input type="checkbox"/> Do not have a personal provider. <input type="checkbox"/> Do not send to my personal provider.
--