

Consumer Self-Report Tobacco Assessment

Today's Date: _____

Name: _____ Gender: M F

Date of Birth: _____ Age: _____

Tobacco Use –

1. Please check the appropriate box for each type of tobacco:

| | | |
|--|------------------|-----------------------|
| 1a CIGARETTES | Never Used | |
| | Used in the Past | |
| | Currently Use | |
| | | |
| 1b PIPE | Never Used | |
| | Used in the Past | |
| | Currently Use | |
| | | |
| 1c CIGARS | Never Used | |
| | Used in the Past | |
| | Currently Use | |
| | | |
| 1d CHEWING TOBACCO | Never Used | |
| | Used in the Past | |
| | Never Used | |
| | Currently Use | |
| 2. What age were you when you first used or tried tobacco? | | |
| 3. What age were you when you started using tobacco on a regular basis? | | |
| 4. How many cigarettes do you smoke each day? | | |
| 5. How many minutes after you wake up do you smoke your 1 st cigarette? | | |
| 6. Do you sometimes awaken at night to have a cigarette or use tobacco? | | Yes _____ No _____ |
| 7. Who smokes in your household? Please check all that apply: | | |
| | | No One |
| | | Parents |
| | | Brothers/Sisters |
| | | Significant Other |

| | |
|---|-----------------------|
| Roommates | |
| 8. Do you smoke indoors at home? | Yes _____ No _____ |

9. How **important** is it to you to stop tobacco use now?

Please check one box.

| | | | | | | | | | |
|------------|---|---|--------------------|---|---|---|---------------------|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at All | | | Average Importance | | | | Extremely Important | | |

Tobacco-Related Illness

10. Have you in the past or do you now have any of the following?

(Check all that apply)

| | | | |
|---------------------------|-------------------------------------|----------------------------|------------------------|
| | Arrhythmia/ Irregular Heart Beat | Emphysema | Obesity/ Overweight |
| | Asthma or Chronic Bronchitis | Halitosis/ Bad Breath | Peptic Ulcer |
| | Cancer (List Type Below) | Heart Attack/ Disease | Pneumonia |
| | Circulatory Problems | Impotence | Seizures |
| | Diabetes | Infertility | Stroke |
| | Early Menopause | Influenza/ Frequent Flu | Wrinkles |
| Other illness (describe): | | | |

Desire to Quit

11. Please check the number next to **the one statement that best describes** your current situation:

| | | |
|-----|---|--|
| 11a | I currently smoke/use tobacco and I do not want to quit in the next 6 months. | |
| 11b | I am seriously considering quitting in the next 6 months, but not in the next 30 days | |
| 11c | I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by half or more), but am not interested in quitting totally. | |
| 11d | I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get. | |

12. How **confident** are you that you will succeed in stopping your tobacco use now? Please check one box.

| | | | | | | | | | |
|------------|---|---|--------------------|---|---|---|---------------------|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at All | | | Average Importance | | | | Extremely Important | | |