Tobacco Control

Patient Name: ______________________________________ **Date:** _________________________

Are you a:

Current Smoker: Y or N	If yes, are you a light or heavy tobacco smoker? ______________
Former Smoker	How long ago did you stop smoking: ________________________
Never a Smoker	

If you are a current tobacco user, please circle all applicable:

Chain smoker	Chews fine cut tobacco	Chews loose leaf tobacco
Chews plug tobacco	Chews tobacco	Chews twist tobacco
Smokes 1-9 cigarettes/day	10-19 cigarettes/day	20-39 cigarettes/day
40+ cigarettes/day	Rolls cigarettes	Snuff user
Trivial smoker less than 1 a day	User of moist powdered tobacco	Pipe User

If you are a former tobacco user, please circle all applicable:

Current non-smoker	Ex-1-9 cigarettes/day	Intolerant ex-smoker
Ex-cigar smoker	Ex-10-19 cigarettes/day	Ex-pipe smoker
Ex-cigarette smoker	Ex-20-30 cigarettes/day	Ex-trivial smoker
Ex-cigarette smoker amount unknown	Ex-40+ cigarettes/day	Ex-user of moist powder

If you are a non- tobacco user, please circle all applicable:

Aggressive non-smoker	Non-smoker for religious reasons
Intolerant non-smoker	Non-smoker for personal reasons
Non-smoker for medical reasons	Tolerant non-smoker