

8. How soon after awakening do you smoke your first cigarette?
- Within 5 minutes
 - Within 6 to 30 minutes
 - Within 31 to 60 minutes
 - After 60 minutes
9. Do you find it difficult to refrain from smoking in places where it is not allowed, like church, movies, libraries, etc.?
- Yes
 - No
10. Do you smoke when you are so ill that you are in bed most of the day?
- Yes
 - No
11. Do you smoke more frequently during the first hours after waking?
- Yes
 - No
12. Which cigarette would you hate most to give up?
- The first cigarette in the morning
 - All others
13. Have you **in the past** had symptoms, a disease or illness you believe was caused made worse by your smoking?
- Yes, describe _____
 - No
14. Do you **now** have symptoms, a disease or illness you believe was caused made worse by your smoking?
- Yes, describe _____
 - No
15. Do you have a history of depression?
- Yes
 - No
16. If yes, were you treated with medication for depression?
- Yes, the medication was _____
 - No
17. Are you currently taking medication for depression?
- Yes, the medication is _____
 - No
18. Do you have a history of anxiety?

- Yes
- No

19. If yes, were you treated with medication for anxiety?

- Yes, the medication was _____
- No

20. Are you currently taking medication for anxiety?

- Yes, the medication is _____
- No

D. Medical History	Yes	No	If Yes, please specify:
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____

Height: _____ ft. _____ in. Weight: _____ lbs. Preferred Weight: _____ lbs.

Pregnant Yes No Don't Know Doesn't Apply

Breastfeeding: Yes No

E. Family History (check all that are positive)

- Cancer
- Heart Disease
- Stroke
- Diabetes
- High Blood Pressure
- High Cholesterol

F. Current prescription/non-prescription drugs you take at least once a week

Name	Dose	Frequency	Reasons for taking

Medication Allergies: _____

G. Quitting History:

1. How many times in your life have you seriously tried to quit smoking and not smoked at least 24 hours? _____
2. When was your last quit attempt?
 - Never tried to quit (**Skip to section H**)
 - Within the last month
 - Within the last year
 - Over 1 year ago
 - Over 2 years ago
3. Why did you stop that time? _____
4. How did you stop? _____
5. How long did you go without smoking that time? _____
6. Have you ever joined a stop smoking group or program, or sought professional help with quitting?
 - Yes
 - No
7. Have you ever used any of the following to help you stop smoking?

a. Nicotine gum	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Nicotine patch	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Nicotine inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Nicotine nasal spray	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Zyban or Wellbutrin	<input type="checkbox"/> Yes	<input type="checkbox"/> No

- Yes, have already stopped
- Yes, in the next 30 days
- Yes, in the next 6 months
- Undecided
- Not planning to stop

8. Are you ready to set a date to quit smoking?

- Yes
- No

9. If you were to quit smoking, how concerned would you be about the possibility of gaining weight?

Not at all Concerned *Very Concerned*

1 2 3 4 5 6 7 8 9 10

I. Drug and Alcohol Use

1. How much of the following do you drink per day?

- Regular coffee (10 oz cup): _____
- Tea (bags): _____
- Cola (12 oz): _____
- Decaffeinated drinks: _____

2. Do you ever drink alcohol:

- Yes
- No (skip to question 6)

3. About how often do you drink alcohol?

- Daily or almost daily
- 3 or 4 times per week
- 1 or 2 times per week
- 1 or 2 times per month
- Less than once per month

4. During the past month, did you drink 5 or more alcoholic drinks in a day?

- Yes
- No

5. Do you use any of the following drugs (check all that apply):

- Marijuana
- Cocaine
- Heroin
- Other

6. Have you ever been dependent on other drugs (prescription or non prescription)?

Yes

No

7. Below is a list of the ways you might have felt or behaved in the past week.

<i>During the past week...</i>	Rarely or none (<1day)	Some or a little (1-2 days)	A moderate amount (3-4 days)	Most or all (5-7 days)
a. I was bothered by things that usually don't bother me				
b. I did not feel like eating; my appetite was poor.				
c. I felt I could not shake off the blues even with help from my family or friends.				
d. I felt that I was as good as other people				
e. I had trouble keeping my mind on what I was doing.				
f. I felt depressed.				
g. I felt that everything I did was an effort.				
h. I felt hopeful about the future.				
i. I thought my life had been a failure.				
j. I felt fearful.				
k. My sleep was restless.				
l. I was happy.				
m. I talked less than usual.				
n. I felt lonely.				
o. People are unfriendly.				
p. I enjoyed life.				
q. I had crying spells.				
r. I felt sad.				
s. I felt that people disliked me.				
t. I could not get going.				