## Step 1: For you to fill out.

**Date:** __________ **Patient's Name:** ______________________________

**Relationship to patient (circle one):**

*Mother* *Father* *Other :* ______________________

**Your Email (optional):** ________________________________________

**Does your child live with anyone who smokes tobacco?**

*Yes* *No*

**If yes, who?** ________________________________________

**Have you smoked tobacco, even a puff, in the last 7 days?**

*Yes* *No, quit in past year* *No, quit over a year ago* *No, never*

**If you smoke, how interested are you in quitting?**

*A lot* *Some* *A little* *Not at all*

**If you smoke, are you interested in medicine to help you quit?**

*Yes* *No* *Not sure*

**If you smoke, do you want to learn free ways to help you quit?**

*Yes* *No* *Not sure*

**Does anyone smoke in your home ever?**

*Yes* *No*

**Does anyone smoke in your car ever?**

*Yes* *No* *No car*

## Step 2: For the doctor/nurse to fill out.

**The doctor or nurse may talk to you about protecting others from the harms of smoking. They may use the check boxes to best meet your needs.**

*Quitting smoking is one of the best things that you can do for your health and the health of your family.*

- ❑ Set a quit date for ______________________________

*Medicine can double your chance of quitting smoking for good.*

- ❑ Medication prescribed: __________________________

*A free telephone quitline or online service is available to help you quit smoking.*

- ❑ Quitline form faxed
- ❑ Online program information emailed/given

*Make a no smoking rule for everywhere in your home and car.*

- ❑ Halflet given

**Progress notes:**

___/___/___ : ________________________________________

________________________________________________

___/___/___ : ________________________________________

________________________________________________

___/___/___ : ________________________________________

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