

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:

____ / ____ / ____ : _____

____ / ____ / ____ : _____

____ / ____ / ____ : _____