STEP 2A: PATIENT ASSESSMENT – CESSATION OF TOBACCO

Patient Information:		
Name:		**Date:**
Mailing Address:		**Declaration of Consent**: I agree to receive services from my pharmacist under the PACT program and allow my information to be released to or from another healthcare provider as necessary for my care. **Signature:**
Email:		Physician:
Telephone:		Pharmacist:
Gender: ☐ male ☐ female	DOB:	Health Services Number:

Medical History: ☐ Pregnant ☐ Lactating ☐ Liver disease ☐ Kidney disease – CrCl _____

Drug History (Rx, OTC, herbals) / Drug allergies: Alcohol use/wk ____ Tea/coffee/day _____

Patient History (if patient is considering NRT, bupropion or varenicline use):

Do you have a mental health condition?
☐ No ☐ If yes, have you had your medications changed or been in the hospital recently?
☐ No ☐ Yes

Have you tried to harm yourself or had thoughts about harming yourself recently?
☐ No ☐ Yes

Do you have an eating disorder? (e.g. anorexia)
☐ No ☐ Yes

Do you have a history of seizures? (e.g. epilepsy)
☐ No ☐ Yes

Have you had a heart attack within the previous 14 days?
☐ No ☐ Yes

Have you been coughing up blood?
☐ No ☐ Yes

Have you noticed significant weight loss recently without trying to lose weight?
☐ No Yes

Do you have persistent chest pain?
☐ No ☐ Yes

STEP 2B: PATIENT ASSESSMENT – REVIEW OF PATIENT'S SMOKING/TOBACCO USE

How long have you smoked regularly? _____

What is the average number of cigarettes you smoke per day? _____

Do you use tobacco other than cigarettes? ☐ No ☐ Yes Type? _____ Quantity/day _____

Have you tried to quit smoking/tobacco before? ☐ No ☐ Yes If yes, please answer the following:

How many times have you tried to quit? _____

When was your last attempt? _____

Why did you start smoking again? _____

What is the longest period of time you remained tobacco free? _____

What methods have you used before to quit smoking? (e.g. cold turkey, reduce to quit, support group, counseling, acupuncture, virtual cigarettes, nicotine replacement therapy, bupropion SR, varenicline, combination therapy)

_____

If cessation medications were used, complete this table:

Type of Medication Used	**Efficacy (How well did it work?)**	**# of Weeks Used**	**Reason(s) for Stopping**	**Any Side Effects**
Nicotine Patch (7mg, 14mg, 21mg)				
Nicotine Gum (2mg, 4mg)				
Nicotine Inhaler				
Nicotine Lozenge 1mg, 2mg, 4mg				
Nicotine Mist				
Bupropion SR (Zyban®)				
Varenicline (Champix®)				
Other				