State Employees' Insurance Board (SEIB) Healthcare Center
101 South Union Street
Montgomery, AL 36104
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Patient Name: _____ **Date of Birth:** _____
Address: _____ **Age:** _____
_____ **Physician (GP):** _____
_____ **Specialist:** _____
E-mail: _____ **Pharmacy:** _____
Phone #: _____ _____
Insurance Contract #: _____ **SWC Advertising Source:** _____

CC:

- Why do you wish to quit tobacco usage? (Are you having any Tobacco-related health problems, etc.)_____
  _____
  _____

HPI: (Tobacco History)

- At what age did you begin using tobacco?_____
- How many years have you used tobacco products?_____
- How many packs per day (on average) do you currently smoke?_____
- Have you ever smoked more or less than you do now? If so, please quantify (example: 2 packs per day for 10 years and then 1 pack per day for 5 years)_____
- Have you ever attempted to quit tobacco?_____
- How many quit attempts have you made?_____
- When was your first attempt to quit tobacco?_____What method did you use for this quit attempt? (cold turkey, nicotine patch, etc.)_____
- When was your last attempt to quit tobacco?_____What method did you use for this quit attempt? _____
- What other tobacco cessation methods have you tried?_____
  _____
- What tobacco cessation methods were effective?_____
  _____
  How long did you quit tobacco after using this (these) method(s)?_____What triggered you to start tobacco again?_____
- What tobacco cessation methods were ineffective?_____
  _____
- Have you ever used any pharmacotherapy (nicotine replacement therapy or bupropion)?_____

Reasons for Tobacco:

- Why did you first begin tobacco?_____
- What do you enjoy most about tobacco?_____
- Are there situations which cause you to use tobacco more?_____If so, what are they? _____
  Are they stress-related?_____
- Do you experience anxiety, moodiness, or other withdrawal symptoms when trying to quit tobacco?____ If so, please rate the severity of your withdrawal symptoms using a scale of 1= least severe to 10= most severe:
  Symptom 1:_____ Severity Rating:_____
  Symptom 2:_____ Severity Rating:_____
  Symptom 3:_____ Severity Rating:_____

Tobacco Patterns:

- Where do you use tobacco products?_____
- Does your job make it easier or more difficult to use tobacco products?_____
  Do you take tobacco breaks?_____ If so, how many per work day?_____
- What time of the day do you use tobacco the most?_____
- Do you drink alcohol?_____ If so, what kind, how much, and how often?_____
  _____ Do you use tobacco more when you drink alcohol?_____
- Is there anything that you are currently doing to cut down on the number of cigarettes that you smoke? (examples: gum, hard candy, etc.)_____

Motivation:

- When do you think you could quit tobacco? (today, next week, < 6 months, >6 months)_____
- How confident are you that you can quit tobacco and stay quit for 1 year or more? (Highly confident, Somewhat confident, Unsure)_____
- Do you anticipate any barriers to tobacco cessation?_____
  _____

Diet and Exercise:

- Is weight gain as a result of tobacco cessation a concern for you?_____
- Do you currently exercise?_____ If so what type of activity do you engage in?_____
  _____ How many times per week do you exercise? _____
  _____For how long each time?_____

- Does Tobacco interfere with any exercise activities that you enjoy? _____
- What are other barriers to exercise do you experience? _____

PMH:

- Provide some information concerning your current and past health: (Example: High Blood Pressure for 5 years) _____

  _____

  _____
- Describe your past surgeries: (Example: Tonsilectomy when 16) _____

  _____
- Do you have any of the following health problems? *(Circle all that apply)*

High Blood Pressure (HTN)	Lung Cancer	Stomach Ulcers
High Cholesterol	Other Cancer	Heartburn (GERD)
High Triglycerides	Emphysema	Low Bone Density (Osteoporosis)
Heart Problems (AMI, CAD)	Chronic Bronchitis	Sexual Problems (ED)
Stroke(s) (TIA, CVA)	Asthma	Infertility/ Miscarriage/ Low Birth Wt
Heart Failure (CHF)	Allergic Rhinitis	Depression
Seizures	Skin Allergies (Eczema)	Are you currently pregnant?_____
Diabetes	Sinusitis	Kidney problems
Thyroid Disease	Overweight / Obesity	Liver problems

FH:

Provide some information concerning your family's health: (Are the following relatives still living? If not, what were their ages at death? What were the causes of their deaths? What other health problems did they have during their lives? If they are still living, do they have any health problems or take any medications daily?)

- **Father:** _____
- **Mother:** _____
- **Paternal Grandparents:** Male:_____

  Female:_____
- **Maternal Grandparents:** Male:_____

  Female:_____
- **Brothers:** _____
- **Sisters:** _____
- **Children:** _____

Be sure to include information concerning cancer, lung disease, asthma, allergies, heart disease, stroke, heart attacks, high cholesterol, etc.

SH:

- Do you drink alcoholic beverages? _____ If so, what kind do you prefer?_____ _____ How often do you drink?_____ How much do you drink each time?_____
- Do you have a history of alcohol abuse? _____ Drug abuse?_____
- Do you use recreational drugs? How often? (Marijuana, Cocaine, etc.) _____
- Does anyone in your /home or work environments smoke? _____
- Do you ingest caffeine? (Coffee, Tea, Colas, Chocolate, etc.) _____
- What is your level of education?_____
- What is your occupation?_____
- Is Tobacco allowed in your work environment?_____
- Do you have a support network of family or friends who will assist you / support you with your quit attempt?_____
- What are your hobbies / major interests?_____

Medication History:

- List all prescription medications that you take on a routine or as needed basis. (Include medication names and doses and how frequently you take them.)_____
- List any over-the-counter medications (including vitamins and herbs) that you take on a routine or as needed basis. (Include medication names and doses and how frequently you take them.)_____

Be sure to include any medications for seizures, asthma, eating disorders, hypertension, MAOIs, wellbutrin (bupropion), etc.