

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: <input type="checkbox"/> male <input type="checkbox"/> 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				