Patient Tobacco Treatment Intake Form

Date: ________ Time: ________ Pharmacist's Name: ________

SECTION 1: PATIENT INFORMATION

Name (Last, First): ________ Date of Birth (Must be 18+): ________ Gender: ____

Primary Phone Number: ________ Home Address: ________

Insurance Provider: ________

BIN	PCN	CARDHOLDER ID	GROUP NUMBER

PCP Name: ________ PCP Phone Number: ________

SECTION 2: MEDICAL CONDITIONS

Current Medical Conditions:

____
____
____

Past Medical Conditions:

____
____
____

SECTION 3: HIGH-RISK SCREENING

1. Pregnant or planning to become pregnant in the next 6 months? ☐ **No** ☐ **Yes**
2. Heart attack in past 2 weeks? ☐ **No** ☐ **Yes**
3. History of arrhythmias or irregular heartbeat? ☐ **No** ☐ **Yes**
4. Unstable angina or chest pain with strenuous activity? ☐ **No** ☐ **Yes**
5. History of mental health disorder and is perceived to not be stable? ☐ **No** ☐ **Yes**

IF YES: Consult with or refer patient to PCP.

SECTION 4: OTHER HISTORY

1. Family history of tobacco use or tobacco-related disease: ________
2. Other medical conditions: ________
3. Current living environment: ________
4. Social history: ________

SECTION 5: MEDICATIONS AND ALLERGIES/HYPERSENSITIVITIES

Current Medications: ________

Allergies/hypersensitivities: ________

SECTION 6: ASSESS TOBACCO USE HISTORY

ASK: Are you ready to set a quit date? ☐ **No** ☐ **Yes** (if yes, record quit date below under "Documentation")

ASK: What types of tobacco/nicotine do you use?

TYPE	HOW MUCH AND HOW OFTEN (PER DAY)?	HOW LONG USED?
Cigarettes		
E-cigarettes/JUUL/Vaping		
Smokeless Tobacco (Dip, Chew)		
Cigars or Cigarillos		
Other:		

ASK: How many minutes after you wake up do you have your first cigarette/tobacco/nicotine? _________

ASK: Any recent changes in your tobacco/nicotine use? ____

ASK: Have you tried to quit before? ☐ **No** ☐ **Yes**

If YES: How many times?______ When was last quit attempt? _______ Longest quit attempt? _______

ASK: Did you call the tobacco quitline or participate in any other form of counseling? ☐ **No** ☐ **Yes**

If YES: What did you like, or not like, about it?____

ASK: What quitting medicines have you tried in the past? Discuss effectiveness, withdrawal symptoms, how med was taken (daily and duration), overall experience (does it make sense to try it again?).

____

____

ASK: Main reasons for returning smoking/tobacco use? Anticipated challenges this time?

____

____

DOCUMENTATION

IF READY TO SET QUIT DATE: Complete the following and initial to the left of each requirement.

____ Discuss medication options and select treatment

____ Ask patient to choose a quit date (if using bupropion SR or varenicline, consider medication start date)

Patient's planned quit date is: _______________

____ Refer patient to Vermont Quitline (**1-800-QUIT-NOW**) or other program: _________________________

____ Document treatment plan

____ Schedule follow-up appointment within 2 weeks of quit date:

Date & Time: _______________ **Check One:** ☐ In-Person ☐ Phone **ASK:** Preferred Contact # _____________

____ Advise patient to follow-up with PCP

____ Contact patient's PCP within 3 business days

Content Courtesy of Indiana Pharmacists Association