Outcomes

TOBACCO CESSATION THERAPY

PATIENT INFORMATION *(Please print clearly)*

Last Name:	**First Name:**	**D.O.B.:**	**Age:**	**Gender:**	**Height:**	**Weight:**
Home Address:		Contact Phone:				
City:		State:		Zip:		
Primary Care Physician:		Physician Phone:				
Physician Address:		Physician Fax #:				
Please state any past medical history and chronic conditions:						
Current medications:						
Allergies (please state reaction that occurs when exposed to the allergen):						

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
For women: are you currently pregnant?	☐	☐	☐
Have you attempted to use tobacco cessation medication in the past? *If yes, please describe what was used, how many attempts there were, and if there were any intolerances to the medication.*	☐	☐	☐
Do you have a history of any of the following conditions: seizures, eating disorders, mental illness, cardiac arrhythmia, renal impairment, hepatic impairment? *If yes, please indicate which one:*	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per week?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐