Smoking Cessation Questionnaire

Date: _____ Patient's Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Primary Care Provider (name & number): _____

Do you have health insurance? (circle one) Yes / No

Medications:

Please list all medications (prescription and over the counter):

1._____ 6._____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10._____

Medication Allergies:

1._____ 2. _____

Section 1: Background Information	
1. Are you under the age of 18 years?	☐ Yes ☐ No
2. How many cigarettes do you smoke per day?	
3. How many years have you smoked?	
4. Do you use smokeless tobacco like chewing tobacco, dip, or snuff?	☐ Yes ☐ No
5. Have you tried to quit in the past? - If yes, what method did you use? (Please mark all that apply): ☐ Patches ☐ Gum ☐ Medications ☐ Quit cold turkey ☐ Other: _____	☐ Yes ☐ No
6. Are you currently taking any medications to help you quit smoking? - If yes, what method? _____	☐ Yes ☐ No
7. Are you interested in a specific medication to help you quit smoking? ☐ Nicotine products (gum, patch, inhaler) ☐ Bupropion (Zyban/ Wellbutrin) ☐ Chantix ☐ No preference	

Section 2: Medical History	
1. Do you or have you ever had seizures or epilepsy?	☐ Yes ☐ No
2. Do you or have you ever taken medications to prevent seizures?	☐ Yes ☐ No
3. Do you or have you ever had an eating disorder?	☐ Yes ☐ No
4. Do you or have you ever experienced any of the conditions? (Please mark all that apply) ☐ Heart attack ☐ Arrhythmias (irregular heartbeats) ☐ Chest pain	☐ Yes ☐ No
5. Do you or have you ever experienced any of the following conditions? (Please mark all that apply) ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Manic disorder ☐ Schizophrenia ☐ Other mental illness: _____	☐ Yes ☐ No
6. Do you or have your experienced any of the following conditions? (Please mark all that apply) ☐ Liver disease ☐ Kidney disease ☐ Decreased kidney function	☐ Yes ☐ No
7. Have you ever had a bad reaction to buproprion (Zyban/Wellbutrin), Chantix, or Nicotine gum, patches, inhaler or lozenges? - If yes, what happened? _____	☐ Yes ☐ No
8. Are you currently taking, or have you ever taken "MAO-inhibitors" such as isocarboxazid (Marplan), phenelzine (Nardil), rasagiline (Azilect), selegiline (Emsam) or tranylcypromine (Parnate)?	☐ Yes ☐ No
9. Do you or have you ever taken benzodiazepines to help with sleep or anxiety? (Examples are: Xanax, Ativan, Valium, Klonopin, alprazolam, lorazepam, diazepam, clonazepam)	☐ Yes ☐ No
10. Do you drink alcohol? - If yes, do you plan to change the amount of alcohol you drink per week?	☐ Yes ☐ No ☐ Yes ☐ No
11. For women: are you pregnant or planning to become pregnant?	☐ Yes ☐ No

I have filled out this form to the best of my knowledge:

Name (printed): _____

Name (signed): _____

Date:_____

Salida Pharmacy & Fountain's Liability Form

Date:_____

Patient's Name:_____

Date of Birth:_____

Primary Care Physician (name and number): _____

I, _____, have read the Buena Vista Drug Smoking Cessation Packet in full.

- I understand this medication is not intended to be used for a longer duration than discussed.
- I understand use of smoking cessation products do not guarantee success and multiple attempts may be required to quit smoking.
- I understand that after 4-6 weeks if I am not satisfied with my recommended regimen, I will call the pharmacist for an appointment to discuss further options.
- I understand if I am not a candidate or the pharmacist recommends I need to see my primary care physician, it is my responsibility to make an appointment.
- I understand that my primary care physician will be faxed if a smoking cessation medication or over-the-counter product is prescribed to me for unity of care.
- If I do not have a primary care doctor it is my responsibility to keep a copy of this visit from my records.
- I understand the pharmacy will operate under the facility's policies and procedures to ensure my privacy and confidentiality is maintained.
- I understand the risks of using smoking cessation products and Buena Vista Drug is not responsible for any of these risks, including manic episodes, exacerbation of psychiatric disorder/mental illness, consequences associated with hypertensive emergency, cardiovascular events, and seizure.
- I understand this appointment does not replace the importance of receiving regular care from a primary care physician.
- I understand that the pharmacist is practicing their Colorado State Board of Pharmacy Approved Statewide Protocol for Prescribing Hormonal Contraceptive Patches and Oral Contraceptives per 17.00.50 Evidence-Based Healthcare Service Pursuant to Statewide Protocol of Division and Appendix B of the Department of Regulatory Agencies: State Board of Pharmacy Rules per Colorado Board of Pharmacy.

I fully understand the medication being prescribed to me, I have asked all questions I had, and I am responsible to take the medication as it is prescribed by FDA.

_____ /___/_____

(Name, printed) (Date)

_____

(Name, signed)