

Patient Survey

Advice to Quit from Health Care Provider

Please complete this survey and return it to (designated staff). Your answers are important and will help us give you and other (name of clinic) patients the best medical care possible.

Date of Birth: ____/____/____

Gender: Male
 Female

Ethnicity: Asian American
 African American
 Caucasian
 Mexican American
 Other Hispanic
 Native American
 Other

1. Have you **ever smoked** at least **100 cigarettes** (or equivalent amounts of cigars, pipe tobacco or chew) in your life?
- Yes
 No

If you answered “**No**” to question one, **do not** answer the remaining questions.

2. Do you **currently use tobacco**?
- every day
 some days not at all
3. If you no longer use tobacco, **how long** has it been since you **quit**?
- More than one year
 Within the past year

If you answered “**More than one year**” to question three, **do not** answer the remaining questions.

4. During the past 12 months, have you **been to see a doctor** or other health professional?
- Yes
 No
5. During the past 12 months, have you been **advised to quit using tobacco** by a doctor or other health professional?
- Yes
 No
6. Would you like to completely quit using tobacco?
- Yes
 No
7. During the past 12 months, have you **quit using tobacco** for one day or longer?
- Yes
 No

Thank you for your help!

