



Tobacco Cessation Program

Registration Form

All information on this questionnaire is kept confidential.
(Please print clearly and bring this to your first appointment)

Name: _____ Today's Date: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell phone #: _____

Email Address: _____

Best time to call: _____ Best place to call: Home Work Cell # E-mail

Date of Birth: _____ Gender : Male Female

How did you hear about us? _____

- How many in household are smokers?(including you): _____
- Do you have any "No-Smoking Rules"? (You don't allow yourself to smoke...)(Please circle)
In House In Car In Both None of these

Medical History

- Do you have a regular doctor or nurse practitioner? Yes No
- Name of doctor, nurse practitioner, or medical office/clinic: _____
- Did a healthcare provider talk to you about quitting tobacco use? Yes No
- Have you ever been diagnosed with the following?: (circle all that apply)

Respiratory problems:	Yes	No	Osteoporosis:	Yes	No
Cancer:	Yes	No	Depression:	Yes	No
Diabetes:	Yes	No	Seizure:	Yes	No
Heart Disease:	Yes	No	Eating Disorder:	Yes	No
High Blood Pressure:	Yes	No	Mental Illness:	Yes	No
- Women: Are you pregnant? Yes No
- Are you treated or medicated for any other medical conditions? Yes No
- If so, please explain (list medication) _____
- Are you being treated for emotional problems? Yes No
- How many alcoholic drinks do you consume in a day? (Please circle):
None 0-2 3-4 5-6 More than 6 Binge drinking

