REACH TOBACCO SCREENING FORM

MRN: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Time In:_____ Time Out:_____ Race//Ethnicity:_____

Primary Language:_____ SCRIPT Counselor:_____

○ Prenatal # of weeks: _____ Date: _____ / _____ / _____ Month Day Year	CO VALUE _____ PPM _____(date) ○ Refused ○ Equipment Problem ○ Explanation in Progress Notes ○ Not Enough Time ○ Other: _____

☐ Need to Call to Set Date Screening Appointment (phone #_____)
☐ Screening Appointment Set for another time (date: _____ and time:_____)
☐ Screening to be Completed at this visit, (*Complete below*)

1. Which statements best describes your current tobacco use? (**choose all that apply**)
   - ☐ I have **never** smoked cigarettes. (Mark here if you have only tried smoking) *Skip to Question 2*
   - ☐ I stopped smoking **BEFORE** I found out I was pregnant – I am not smoking. *Skip to Question 2*
   - ☐ I stopped smoking **AFTER** I found out I was pregnant – I am not smoking. *Skip to Question 2*
   - ☐ I dip, chew or use smokeless tobacco.
   - ☐ I smoke e-cigarettes/vapor
   - ☐ I smoke regularly now – about the same number **BEFORE** I became pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
   - ☐ I have increased smoking since I found out I was pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
   - ☐ I have started smoking since I found out I was pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
   - ☐ I have decreased smoking since I found out I was pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
2. How many cigarette smokers live in the same house with you? (choose only one)
   ○ None ○ 1 ○ 2 or more ○ don't know ○ refuse to say
3. How is cigarette smoking handled where you live? (choose only one)
   ○ No one smokes where I live – they smoke outside. ○ Don't know
   ○ People may only smoke in certain rooms where I live. ○ Refuse to say
   ○ People may smoke anywhere I live.
4. How many of your family and friends are cigarette smokers? (choose only one)
   ○ None ○ A few ○ Some ○ Most ○ Don't know ○ Refuse to say

If Never Smoked or Recently Quit – STOP HERE **Continue Below ONLY if Currently Smoking Tobacco**

5. How soon after you wake up do you usually use tobacco? (choose only one)
   ○ 5 minutes or less ○ 6 to 30 minutes ○ 31 to 59 minutes ○ 1 to 2 hours ○ Greater than 2 hours DK Ref
6. How sure are you that you could/can stop smoking for 24 hours? (choose only one)
   Low ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 High DK Refused
7. How harmful do you feel cigarette smoking tobacco is to you? (choose only one)
   Low ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 High DK Refused
8. How harmful do you feel cigarette smoking tobacco is to your baby? (choose only one)
   Low ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 High DK Refused
9. Have you participated in a Smoking Cessation Program before: (choose only one) _____Yes _____No _____ Don't know Ref
10. Have you had a visit to the doctor or healthcare provider in the past 12 months? ○Yes ○No DK Ref
11. My doctor or healthcare provider advised me to quit? ○ Yes ○ No DK Ref
12. I have used the Oregon Quitline? ○Yes ○ No DK Ref
13. Do you want to quit? ○ No ○ Yes ○ Reduce DK Ref
14. What motivates you to quit?