

**Tobacco Cessation Program
Registration Packet**

NOTE: This form can be incorporated into DA Form 4700, Supplemental Medical Data and kept in the participant's medical record.

Tobacco User Profile – Page 1

Name						
Age	Height	Weight	<input type="checkbox"/> Male	Day Phone	Evening Phone	E-mail
			<input type="checkbox"/> Female			
Number of persons in your household:				Number of persons in your household that use tobacco (include yourself):		
What type of tobacco products do you use? <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Smokeless						
If you smoke cigarettes, how many per day? <input type="checkbox"/> Less than ½ pack <input type="checkbox"/> ½ - 1 pack <input type="checkbox"/> 1-1/2 – 2 packs <input type="checkbox"/> More than 2 packs						
If you use smokeless tobacco, what type? <input type="checkbox"/> Dip <input type="checkbox"/> Chew						
How much per day? <input type="checkbox"/> Occasional, not daily <input type="checkbox"/> A few times <input type="checkbox"/> ½ can <input type="checkbox"/> About 1 can <input type="checkbox"/> More than a can						
How old were you when you began to use tobacco?						
Have you tried to quit before now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?						
If you tried to quit before now, what is the longest time you were free of tobacco use? <input type="checkbox"/> Less than 24 hours <input type="checkbox"/> 1 – 2 days <input type="checkbox"/> 3 – 7 days <input type="checkbox"/> 2 – 4 weeks <input type="checkbox"/> 6 – 8 weeks Other:						
What resources have you had to support stopping tobacco use?						
What is the primary reason you returned to tobacco use?						
List all known allergies:						
Check all medical conditions that apply to you:						
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Alcohol addiction		
<input type="checkbox"/> Chest pain		<input type="checkbox"/> Insomnia		<input type="checkbox"/> Drug addiction		
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Fatigue		<input type="checkbox"/> Depression		
<input type="checkbox"/> Irregular heart beat		<input type="checkbox"/> Frequent headaches		<input type="checkbox"/> Seizures		
<input type="checkbox"/> Coughing spells		<input type="checkbox"/> Liver disease		<input type="checkbox"/> Emphysema		
<input type="checkbox"/> Frequent colds		<input type="checkbox"/> Vision problems		<input type="checkbox"/> TMJ Syndrome		
<input type="checkbox"/> Asthma		<input type="checkbox"/> Stroke		<input type="checkbox"/> Cancer (type):		
Prepared by: <i>(signature and title)</i>			Department/Service/Clinic		Date	

PARTICIPANT IDENTIFICATION

Name _____
SSN _____ Rank _____
Unit _____
Status: __ ADA __ RET
__ ADAFM __ RETFM
__ VET __ CIV

Tobacco User Profile – Page 2
Tobacco Cessation Weekly Program Monitor

Weekly Program Monitor

Name:				Quit Date:			
Session	Date	Weight	CO Reading	Tobacco Use? (+,-,Other)	Medication Issued (specific prescription)	Participant Initials	Facilitator Initials
1							
2							
3							
4							
5							
6							

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Tobacco Use Evaluation

S	Age _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Years of Use _____	Packs Per Day _____	Cans Per Day _____
1. More than one pack per day or uses dip/chew daily:				<input type="checkbox"/> Yes (2)	<input type="checkbox"/> No (0)
2. Uses tobacco within 1 hour of waking:				<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
3. When attempting to quit in past, experienced withdrawal symptoms: (anxiety, nervousness, irritability, sleeplessness, etc.)				<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
4. Desires to use Nicotine Replacement Therapy (patches or "gum"):				<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
5. How motivated to quit?					
<input type="checkbox"/> Not at all (-2)		<input type="checkbox"/> A little (0)		<input type="checkbox"/> Moderate (1)	
<input type="checkbox"/> Very motivated (2)					
6. Pregnant or lactating female:				<input type="checkbox"/> Yes (-3)	<input type="checkbox"/> No (0)
7. Unstable cardiovascular disease:				<input type="checkbox"/> Yes (-4)	<input type="checkbox"/> No (0)
DECISION WEIGHING SCALE					
-9 -8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7					
NRT NOT ADVISED			NRT HIGHLY ADVISED		
PMH (Check those that apply)					
<input type="checkbox"/> ASTHMA <input type="checkbox"/> COPD <input type="checkbox"/> CAD <input type="checkbox"/> CVA <input type="checkbox"/> HTN <input type="checkbox"/> SEIZURES <input type="checkbox"/> OTHER:					
ALLERGIES:			CURRENT MEDICATIONS:		
O	Well Developed, Well Nourished; No Acute Distress			Center for Epidemiologic Studies Depression Scale SCORE:	
	<input type="checkbox"/> YES <input type="checkbox"/> NO				
A	Evidence of nicotine dependence.				
P	NRT Prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, Check prescribed protocol:		
	NICODERM PATCH <input type="checkbox"/> 21 mg x 4 weeks 14 mg x 1 week 7 mg x 1 week <input type="checkbox"/> 35 mg x ___ weeks	NICODERM PATCH <input type="checkbox"/> 14 mg x 4 weeks 7 mg x 2 week <input type="checkbox"/> 7 mg x 6 week <input type="checkbox"/> 28 mg x ___ weeks	NICORETTE "GUM" <input type="checkbox"/> 12-24 pieces	OTHER: <input type="checkbox"/> Zyban 150 SR #28; then #14, ref 5 1 po qd for 3 days, then 1 po bid <input type="checkbox"/> Initial blood pressure ___/___	
	TOBACCO CESSATION COUNSELING				
	<input type="checkbox"/> Have advised and counseled patient to avoid ALL tobacco products during NRT treatment <input type="checkbox"/> Nicotine Replacement Therapy Counseling Form reviewed. <input type="checkbox"/> Medication Information Packet given				
PREPARED BY: <i>(signature and title)</i>			Department/Service/Clinic		Date
PARTICIPANT IDENTIFICATION					
Name _____					
SSN _____ Rank _____					
Unit _____					
Status: ADA RET ADAFM RETFM VET CIV					

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Nicotine Replacement Therapy Counseling Form

INITIAL PRESCRIPTION FOR: PATCH GUM BOTH

USER INTIAL	Use may NOT be indicated if: <ul style="list-style-type: none"> ▪ Pregnant, history of recent heart attack, heart palpitations ▪ Active TMJ (for gum use) ▪ Rash/skin disease/allergy to adhesives (for patch use) ▪ Overactive thyroid, kidney or liver disease
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USER INTIAL	The following side effect may occur while using the gum: <ul style="list-style-type: none"> ▪ Dizziness, vomiting/diarrhea, hiccups ▪ Throat/mouth irritation ▪ Jaw muscle/joint aching ▪ Heart palpitations, upset stomach
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USER INTIAL	The following side effects may occur while using the patch and may be symptoms of nicotine overdose:		
	Headache Mental confusion Vivid dreams Upset stomach Vomiting/diarrhea	Cold sweats Excessive salivation Blurred vision Difficulty hearing Weakness/tiredness	Irritability Insomnia Irregular heart beat Dizziness Overdose may cause fainting

USER INTIAL	If worrisome symptoms or problems occur, contact this clinic immediately.
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USER INTIAL	Participant will review the package literature regarding proper use to minimize side effects and increase potential cessation success.
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USER INTIAL	Participant understands that use of tobacco products while using nicotine replacement therapy could result in an overdose.
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USER INTIAL	Patches and gum will be kept out of reach from children and pets. Disposal of used product will consist of: (For Patch) Folding in half, adhesive sides together, placing in pouch after removal of new pouch, and discarding in trash container no accessible to children or pets. (For Gum) Wrapping in paper or foil and discarding in trash container not accessible to children or pets.
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My Quit Date is _____ . I will not use tobacco products while I am using the prescribed nicotine replacement therapy.

Participant's Signature:

Date

Counselor's Name:

Original to record, copy to participant

PARTICIPANT IDENTIFICATION

Name _____
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Center for Epidemiologic Studies Depression Scale

Below are a number of statements about the way you may have felt or behaved during the past week.
Please read each statement and circle how often it was true for you during the last seven days.

DURING THE PAST WEEK:	RARELY or NONE of the time (Less than 1 day)	SOME or LITTLE of the time (1-2 days)	OCCASIONALLY or a MODERATE amount of time (3-4 days)	MOST or ALL of the time (5-7 days)
1. I was bothered by things that don't usually bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with the help of my friends.	0	1	2	3
4. I felt that I was just as good as other people.	3	2	1	0
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	3	2	1	0
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	3	2	1	0
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	3	2	1	0
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get going.	0	1	2	3

SCORE:

PREPARED BY: (Signature and title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PARTICIPANT IDENTIFICATION

Name _____

SSN _____ Rank _____

Unit _____

Status: ___ ADA ___ RET
 ___ ADAFM ___ RETFM
 ___ VET ___ CIV

Tobacco Use Log Instructions

It is very important to track your tobacco use before starting the Tobacco Cessation class. This log will be used to prescribe your nicotine replacement therapy.

Instructions:

- 1) Track your tobacco use 24 hours a day for two weeks.
- 2) Each time you use tobacco, make a tic mark on the day and time.

Example:

Date	1/2	1/3	1/4	1/5	1/6	1/7	1/8
	SUN	MON	TUE	WED	THR	FRI	SAT
1300							
1400							

TOBACCO USE LOG

Date	SUN	MON	TUE	WED	THR	FRI	SAT
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TOTALS							
Zyban							

TOBACCO USE LOG

Date	SUN	MON	TUE	WED	THU	FRI	SAT
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TOTALS							
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