N.H. Board of Pharmacy
Tobacco Cessation Self-Screening Patient Intake Form

Name: _____Date of Birth: _____Age: ____ Today's Date: _____
Today's BP: _____/_____mmHg
Do you have health insurance? ***Yes / No*** Name of insurance provider _PCP/Health Care Provider's Name: _____

_____
List of medicine you take: _____

_____

_____

Any allergies to medicines? ***Yes / No*** If yes, list them here _Any food allergies (ex. menthol/soy): _____

_____
Do you have a preferred tobacco cessation product you would like to use?: _____

Have you tried quitting smoking in the past? If so, please describe: _____

What best describes how you have tried to stop smoking in the past?

- "Cold turkey"
- Tapering or slowly reducing the number of cigarettes you smoke a day
- Medicine
  - Nicotine replacement (like patches, gum, inhalers, lozenges, etc.)
  - Prescription medications (ex. bupropion [Zyban®, Wellbutrin®], varenicline [Chantix®])
- Other: _____

Background Information:

1.	Are you under 18 years old?	□ Yes □ No
2.	Are you pregnant, nursing, or planning on getting pregnant or nursing in the next 6 months?	□ Yes □ No □ Not sure
3.	Are you currently using and trying to quit non-cigarette products (ex. Chewing tobacco,vaping, e-cigarettes, Juul)?	□ Yes □ No

Medical History:

4.	Have you ever had a heart attack, irregular heartbeat or angina, or chest pains in thepast two weeks?	□ Yes □ No □ Not sure
5.	Do you have stomach ulcers?	□ Yes □ No □ Not sure
6.	Do you wear dentures or have TMJ (temporomandibular joint disease)?	□ Yes □ No □ Not sure
7	Do you have a chronic nasal disorder (ex. nasal polyps, sinusitis, rhinitis)?	□ Yes □ No □ Not sure
8.	Do you have asthma or another chronic lung disorder (ex. COPD, emphysema, chronicbronchitis)?	□ Yes □ No □ Not sure

Stop here if patient and pharmacist are considering nicotine replacement therapy.

KEEP GOING

If patient and pharmacist are considering non-nicotine replacement therapy (ex. varenicline or bupropion) continue to answer the questions below.

Medical History Continued:

9.	Have you ever had an eating disorder such as anorexia or bulimia?	□ Yes □ No □ Not sure
10.	Have you ever had a seizure, convulsion, significant head trauma, brain surgery, history of stroke, or a diagnosis of epilepsy?	□ Yes □ No □ Not sure
11.	Have you ever been diagnosed with chronic kidney disease?	□ Yes □ No □ Not sure
12.	Have you ever been diagnosed with liver disease?	□ Yes □ No □ Not sure
13.	Have you been diagnosed with or treated for a mental health illness in the past 2 years?(ex. depression, anxiety, bipolar disorder, schizophrenia)?	□ Yes □ No □ Not sure
14.	Do you take a monoamine oxidase inhibitor (MAOI) antidepressant? (ex. selegiline [Emsam®, Zelapar®], Phenelzine [Nardil®], Isocarboxazid [Marplan®], Tranylcypromine [Parnate®], Rasagiline [Azilect®])	□ Yes □ No □ Not sure
15.	Do you take linezolid (Zyvox®)?	□ Yes □ No □ Not sure
16.	Do you use alcohol or have you recently stopped taking sedatives?(ex. Benzodiazepines)	□ Yes □ No □ Not sure

Tobacco History:

9.		Do you smoke fewer than 10 cigarette

The Patient Health Questionnaire 2 (PHQ 2):

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Suicide Screening:

Over the last 2 weeks, how often have you hadthoughts that you would be better off dead, orthoughts of hurting yourself in some way?	**0**	**1**	**2**	**3**

Patient Signature: _____ Date: _____