QUITWORKS[SM]-RI

Tobacco Use Questionnaire

Date: __ __ / __ __ / __ __
month day year

Name:____

1. Do you now smoke cigarettes?

❑ Yes ❑ No

If yes, how many cigarettes do you smoke a day?

_________ cigarettes

2. Do you use any of these other tobacco products?

❑ Pipe ❑ Snuff ❑ Chewing Tobacco ❑ Cigars

If yes, how many times a day?

_____________ times a day

3. Does anyone in your household smoke?

❑ Yes ❑ No

4. How soon after you wake up do you smoke your first cigarette/use tobacco?

❑ Within 5 minutes ❑ 6–30 minutes ❑ 31–60 minutes ❑ More than 60 minutes

5. How interested are you in stopping smoking/using tobacco?

❑ Not at all ❑ A little ❑ Some ❑ A lot ❑ Very

6. Do you seriously intend to stop in the next month?

❑ Yes ❑ No

7. If you decided to stop completely during the next two weeks, how confident are you that you would succeed?

❑ Not at all ❑ A little ❑ Some ❑ A lot ❑ Very

Thank You!