



# Brattleboro Memorial Hospital Tobacco Treatment Program Registration Form

All information on this questionnaire is kept confidential

Have you enrolled in a tobacco cessation program before?  Yes  No  
If yes, where? \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Shipping Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email (if applicable) \_\_\_\_\_

### Privacy Policy and Consents:

I agree to receive smoking cessation services provided by Brattleboro Memorial Hospital and consent for the use of my health information related to these services for the purposes of my treatment, obtaining payment for the services and the health care operations of Brattleboro Memorial Hospital or other treating providers, all as permitted under the Federal HIPAA privacy regulation effective on April 14, 2003.  
I understand that the information collected here will be used for anonymous data collection.

Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_

Do you give consent for a tobacco program evaluator to follow up on your progress?  Yes  No  
(For state evaluation of program and quit rate analysis; 3 brief calls at 4, 7, 13 months)  
If yes, please circle which number is best to contact you for evaluation? Home Work Cell

Do you give consent for your tobacco counselor to follow up on your progress?  Yes  No  
(For continued counseling and support by local hospital program)  
If yes, please circle which number is best to contact you for counseling? Home Work Cell

### Demographic Information:

Employment Status (Please checkmark):

- |                                     |  |                                    |
|-------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Full time  | <input type="checkbox"/> Retired       | <input type="checkbox"/> Temporary |
| <input type="checkbox"/> Part time  | <input type="checkbox"/> Seasonal job  |                                    |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> Self-employed |                                    |
| <input type="checkbox"/> Disabled   | <input type="checkbox"/> Student       |                                    |

What is your education background? (Please checkmark):

- |  |   |
|--|---|
| <input type="checkbox"/> 8 <sup>th</sup> grade or less | <input type="checkbox"/> Some college   |
| <input type="checkbox"/> Some high school              | <input type="checkbox"/> College grad   |
| <input type="checkbox"/> High school grad              | <input type="checkbox"/> Post -graduate |

Do you have insurance or any kind of medical coverage? (Please checkmark):  Yes  No  
If yes, are you the primary insured? (Please checkmark):  Yes  No

What is your insurance?

- |                                   |                                |                                      |
|-----------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> MVP   | <input type="checkbox"/> VA Benefits |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Cigna | <input type="checkbox"/> NAP         |
| <input type="checkbox"/> VHAP/PC+ | <input type="checkbox"/> CBA   | <input type="checkbox"/> Other       |
| <input type="checkbox"/> TVHP     | <input type="checkbox"/> BCBS  | <input type="checkbox"/> Unknown     |

Insurance ID # (found on the front of your insurance card) \_\_\_\_\_

Special population (Please checkmark):

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Hispanic        | <input type="checkbox"/> Asian               | <input type="checkbox"/> GLBT         |
| <input type="checkbox"/> Afro-American   | <input type="checkbox"/> Confined population | <input type="checkbox"/> Hospitalized |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____         |                                       |

How many people are in your household?: \_\_\_\_\_ # less than 18 yrs old: \_\_\_\_\_  
How many in household are smokers? \_\_\_\_\_

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

What or who referred you for assistance to quit tobacco? (Please checkmark):

- |  |  |                                |
|--|--|--------------------------------|
| <input type="checkbox"/> Employer                        | <input type="checkbox"/> Radio         | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other health care worker        | <input type="checkbox"/> Self          |                                |
| <input type="checkbox"/> Doctor or primary care provider | <input type="checkbox"/> TV            |                                |
| <input type="checkbox"/> Printed word                    | <input type="checkbox"/> Word of mouth |                                |
| <input type="checkbox"/> Quit Line                       | <input type="checkbox"/> Dental Office |                                |

### **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 advise you to quit tobacco use?  Yes  No

Have you ever been diagnosed with the following?:

- |  |  |
|--|--|
| Respiratory problems: <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis: <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No               | Depression: <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No             | Seizure: <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Heart Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No        | Eating Disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No  | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are you treated or medicated for any other medical conditions?  Yes  No

If so, please explain (list medication) \_\_\_\_\_  
\_\_\_\_\_

How many alcoholic drinks do you consume in a day? (Please checkmark)

None  
 0-2  
 3-4

5-6  
 More than 6  
 Binge drinking

**Tobacco History**

What tobacco products do you currently use? (Please checkmark all that apply):

Cigarettes                       Snuff                       Pipe  
 Cigars                               Spit tobacco

What age did you start smoking or using tobacco? (Please checkmark):

Up to age 10                       Age 11-17                       Age 18 or older

How much are you smoking in a day? \_\_\_\_\_ (Circle: packs, pipes, cans or pinches)

What time of day do you smoke or use tobacco the most?

Morning                               Evening  
 Afternoon                               No Difference

How soon after waking do you smoke or use tobacco?

Immediately                       Within 1 hour  
 Within 30 minutes                       After an hour

How many times have you tried to quit? (Write in #): \_\_\_\_\_

When was your most recent attempt to quit? (Give date if possible, or best guess): \_\_\_\_\_

Did you use any of the following in past quit attempts to help you?

Nicotine patch                       Cold turkey                       Hypnosis  
 Nicotine gum                       Cutting back                       Acupuncture  
 Nicotine lozenge                       Counseling  
 Nicotine inhaler                       Other  
 Zyban or Wellbutrin                       Chantix / Varenicline

Do you plan on using any of the above to help you quit this time?  Yes     No

If yes, which one or ones? \_\_\_\_\_  
\_\_\_\_\_

How ready do you feel to quit smoking?

I don't want to make any plans to quit smoking  
 I plan to quit within 6 months  
 I plan to quit within 30 days  
 I'm ready to pick a quit date now but want to discuss it  
 I've already picked a quit date (please write down your quit date):  
Quit Date \_\_\_\_\_

On a scale of 0-10, where 0 is no chance and 10 is absolutely, what do you think your chances of being able to quit for good are at this time? Number \_\_\_\_\_

**Thank you for taking the time to fill out this form.  
You have taken an important step toward becoming a Non-Smoker!**