Instructions for Pharmacist: Please print off a copy, have patient fill out top part, fill out the bottom part with the patient. Once completed, make a copy of the full sheet for your records and then give only the bottom portion to the patient.

Patient Name: ____ **Date Of Birth:** _____________________

Current Medical Conditions: ____

How long have you used tobacco products for? ________________

Do you use *(check all that apply):* ☐cigarettes ☐tobacco e-cigs ☐cigars ☐chewing tobacco ☐pipe tobacco

☐other: ____

How many cigarettes do you typically smoke in a day? ___________ **When do you have your first cigarette?** _____________

Where do you typically use tobacco? *(check all that apply)* ☐at home ☐at work ☐in the car ☐at social gatherings

☐other: ____

What are your triggers/urges? ___________________________________ ____

___________________________________ ____

What are your concerns with quitting (include any potential barriers)? ____

____

Have you tried quitting before? If yes, what methods did you use? ____

What is your anticipated quit date? _______________

Who will be your potential support group? *(check all that apply)*:

☐family/friends ☐coworkers ☐quit lines ☐phone apps ☐support groups

Please stop here.

Quit Date: ________________

How does tobacco impact my life?

____

____

TRIGGER/URGE	COPING METHODS

What are my reasons/goals for quitting?

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________

How can I reward myself after small successes? ____

How can I reward myself after large successes? ____

Personalized NRT Plan: ____