Date of consult:	Patient name:	PHIN:
Address:	City & Province:	Postal code:

Medication & Medical History

Do you have any chronic medical conditions? Check if well controlled.	1. 2. 3. 4.
Do you take any prescription, OTC, or natural medications?	

Agent	Strength	Form	Dosing	Indication

Do you drink alcohol or coffee? How often and how much?	Alcohol: Coffee:
Do you use cannabis or other drugs?	
Pregnant Breastfeeding	Allergies & reactions:

Tobacco Use Habits & History

How many years have you been smoking?		
What types of tobacco products do you use? How much of each product do you use per day?	1. 2. 3.	
What kind of smoker would you describe yourself as? Check all that apply.	Daily Occasional	Social Alone
Where do you usually smoke? Check all that apply.	Home Car Leisure activities	Work Social gatherings Others:
Who in your immediate regular life also smokes? Check all that apply.	Friends Family (household) Significant other	Co-workers Family (non-household) Others:

Add the scores preceding the selected answers in the portion below to determine Fagerstrom nicotine dependency

How soon after waking do you smoke your first cigarette?		
Is it hard to not smoke in places where it's not allowed?		
Which cigarette would you hate to give up most?		
How many cigarettes a day do you smoke? Exact amount:		
Do you smoke more during the morning than rest of the day?		
Do you smoke even if you are sick in bed most of the day?		

Dependence: 0-2 =very low 3-4 = low 5 = moderate 6-7 = high ≥8 = very high

Past Quit Attempts

How many times have you tried quitting before?	When was your last quit attempt?
Which instance and method were your most successful?	What is the longest period of time you've quit for?
What led you to resume using tobacco products each time?	

What have you used/tried in the past to quit smoking? How did you use them?

Agent/Method	Dose/Directions	Reason/s for stopping	Duration Used	Still using?

My quit day is _____. *I am proud of this decision but understand I may have cravings and withdrawal symptoms. These are only temporary, will improve over time, and I can use the personalized strategies outlined below to manage them. If I have any concerns before my next appointment, I can reach my pharmacist at* _____

Plan (Pharmacological)

Patient preferences/concerns (efficacy, convenience, cost/coverage, discretion, interactions, side effects, dosing)

Prescriber Name: _____ Address _____

Address _____

Medication	Strength & Quantity	Directions	Refills

Signature: _____ Date: _____ Price: _____

Monitoring (side-effects, timeframe, endpoints)

Plan (Behavioral)

What are your biggest concerns we should address to making quitting easier? (Check all that apply)

☐ Cravings ☐ Mood ☐ Sleep ☐ Habit
☐ Stress ☐ Social ☐ Hunger/weight gain ☐ Others:

	Patient Concerns	Recommendations
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Next Appointment

Date of 1st follow-up	Week of:
Preferred method	☐ Telephone ☐ In-person