BOW MEDICAL PRACTICE

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Smoking Health Status Questionnaire

Name:

D.O.B:

1. Do you smoke? **Yes** ☐ **No** ☐

2. What do you smoke? **Cigarettes** ☐ **Cigars** ☐ **Pipe** ☐ **Tobacco** ☐

3. How much do you smoke each day?

________Cigarettes ______Cigars ______Oz Tobacco (Rolling your own or Pipe)

1. If you smoked in the past, when did you stop?

2. What did you smoke? **Cigarettes** ☐ **Cigars** ☐ **Pipe** ☐ **Tobacco** ☐

3. How much did you smoke each day?

________Cigarettes ______Cigars ______Oz Tobacco (Rolling your own or Pipe)

Please hand the form to the receptionist once complete.

Thank you for taking the time to provide this information for your health record.