Date ___/___/___ Subject # ☐☐☐☐

BASELINE

SMOKER'S PROFILE

Age: _____ Gender: M F

Ethnicity: _____ Weight:_____lbs. Height: _____ Occupation: _____

Marital Status: _____ Single _____Married _____ Divorced/Separated _____Widower

Circle Highest Completed School Grade:

1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Graduate School: 1 2 3 4 5

Circle your Mother's Highest Completed School Grade:

1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Graduate School: 1 2 3 4 5

Number of persons living in your household who smoke (including yourself): _____

On an average day, how many cigarettes do you usually smoke? _____

Which brand do you most frequently smoke? _____ ( ) Regular ( ) Lights ( ) 100's

What other brand(s) do you currently smoke? _____

How many years have you been smoking? _____

How deeply do you inhale the smoke? _____ Not at all _____ Somewhat _____ Deeply _____ Very Deeply

How many different times in your life have you made a serious attempt to quit smoking? _____

How many different organized programs have you attended to help you quit smoking? _____

What is the longest single period of time you have stayed away from cigarettes? (record numbers)

_____ Years _____ Months _____ Weeks _____ Days _____ None

If you have previously quit, did you experience any unpleasant effects as a result? _____ Yes _____ No

If yes, please explain: _____

_____

How severe were these effects? ____ Very Mild ____ Mild ____ Moderate ____ Severe ____ Very Severe

Do you smoke primarily menthol or non-menthol (>80%) cigarettes? _____ Menthol _____ Non-Menthol

Have you had a physical examination by a physician in the last year? _____ Yes _____ No

Do you have any medical problems? _____ Yes _____ No If yes, please explain:

_____

_____

_____ Heart Disease _____ Lung Cancer _____ Bronchitis _____Emphysema _____Asthma

_____ High Blood Pressure _____ Stomach Problems _____Diabetes _____ None

Are you on medication? _____ Yes _____ No If yes, please explain:

_____

_____

How many cups of the following beverages do you drink on any average day (approximately)?

Coffee: _____

How many of those cups of coffee are:

_____ Brewed _____ Instant _____ Decaffeinated

Tea (caffeinated): _____ Cola Drinks (caffeinated): _____

How many alcoholic drinks do you have per week? _____

How many of those alcoholic drinks are :

_____ Beer _____ Wine _____ Hard Liquor

When do you usually have these drinks? _____ Mornings _____ Afternoons _____ Evenings

Have you ever tried or used any tobacco product(s) other than cigarettes? _____ Yes _____ No

If yes, circle the types of products you've ever tried/used: cigars pipe chewing tobacco

How many (or how much) of the above product(s) have you used in your lifetime? _____

How long ago did you last use the above product(s)? _____