

## Tobacco Dependence Clinic Medical History

Name	Today's Date
Age	

### Medical History

**Please check if you have had in the past/currently have any of the following:**

Physical/Medical	Past	Current	Medication
a. Heart Disease			
b. High Blood Pressure			
c. Diabetes			
d. High Cholesterol			
e. Stroke			
f. Cancer – Type:			
g. Lung Disease (asthma, COPD)			
h. Other:			
Psychological	Past	Current	Medication
a. Depression			
b. Anxiety			
c. Schizophrenia			
d. Bipolar Disorder			
e. Seizure/Convulsions/Epilepsy			
f. Cognitive Disorder (ADHD, Neurological Disorders)			
g. Other:			
Alcohol/Drugs	Past	Current	Usual Quantity and Frequency in past 6 months.
a. Alcohol			
b. Marijuana			
c. Cocaine			
d. Heroin			
e. Other:			

Please list any allergies to medications:

\_\_\_\_\_

What is your weight? \_\_\_\_\_ lbs.    What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches

<b>Please circle YES or NO to the following:</b>	<b>YES</b>	<b>NO</b>
History of depression requiring treatment (medication or counseling)	Y	N
Did you ever feel so bad you wanted to hurt yourself?	Y	N
History of other behavioral problems	Y	N
Kidney or Liver Disease	Y	N
History of seizures, convulsions, epilepsy	Y	N
History of head trauma or brain tumor	Y	N
History of an eating disorder (anorexia, bulimia)	Y	N
Currently on Wellbutrin or Zyban	Y	N
Previous adverse reaction to Wellbutrin or Zyban	Y	N
Currently on a MAO Inhibitor (Nardil, Parnate, Selegeline)	Y	N
Currently on medications that could increase seizures (Antipsychotics, Tricyclic Antidepressants, Theophylline, Ultram)	Y	N
Drink Alcohol	Y	N
Recent withdrawal from alcohol or benzodiazepines (Valium)	Y	N
Difficulty sleeping/insomnia	Y	N
Taking medication or insulin for diabetes	Y	N
Using cocaine, stimulants, diet medications	Y	N
Uncontrolled high blood pressure	Y	N
Pregnant, planning on pregnancy, or breast-feeding	Y	N
Recent heart attack, angina, chest pain, abnormal heart rhythm	Y	N
Previous adverse reaction to nicotine replacement medications	Y	N
Dental or jaw problems	Y	N
Asthma	Y	N
Sinus problems or nasal problems (rhinitis, polyps)	Y	N

### Tobacco Use/Medication Information

How much tobacco do you currently use? \_\_\_\_\_ cigarettes per day

Highest number of cigarettes smoked in the past month \_\_\_\_\_ cigarettes per day

<b>Medications</b>	<b>Used before</b>	<b>Benefits/Side Effects</b>	<b>Interested in using now</b>
Nicotine Patch			
Nicotine Gum			
Nicotine Oral Inhaler (puffer)			
Nicotine Nasal Spray			
Nicotine Lozenge (Commit)			
Zyban/Wellbutrin/Bupropion			
Chantix (varenicline)			

<b>Medication Treatment Plan / Clinic Staff Only</b>			
Quit Date	CO	Medication	Follow Up
<b>Patient evaluated by me.</b>			
<b>I reviewed and concur with medical history.</b>			
<b>I reviewed and concur with medical assessment and treatment plan.</b>			

**Clinician/Doctor** \_\_\_\_\_

**Date** \_\_\_\_\_