UCSF SMOKING CESSATION PROGRAM REGISTRATION FORM

Anyone who use tobacco products and want to quit can join our Smoking Cessation Program. In an effort to help you quit tobacco, we'd like to learn about you and your tobacco use. Your responses on this form will be kept confidential. If you have any questions when filling out the form, please call us at 865-474-1551.

REGISTRATION INFORMATION

Today's Date: ________________

Name: (first)_____________________ (middle) _______________ (last) ___________________

Address: ____

City/State: _____________________ Zip code: ______________ County: _________________

Home Phone number: __________________ **Cell Phone** number: _______________________

E-Mail Address: ____

How did you hear about this program? (*check all that apply*)

- ☐ Family/friends
- ☐ Online research
- ☐ Community events
- ☐ Other: _________________

YOUR CURRENT TOBACCO USE

1. What types of tobacco do you use now or in the past 30 days?
   - ☐ Cigarettes
   - ☐ Cigars, cigarillos, or little cigars
   - ☐ A pipe, hookah, or E-cigarettes
   - ☐ Chewing tobacco or dip
2. What type of smoker are you?
   - ☐ Habitual
   - ☐ Social
   - ☐ Stress
   - ☐ Other: _________________
3. How many cigarettes do you smoke per day on the day that you smoke?
   - ☐ 10 or fewer cigarettes
   - ☐ 11-20 cigarettes
   - ☐ 21-30 cigarettes
   - ☐ 31 or more cigarettes

UNITED WE CARE UNITED WE SHARE

UNITED CANCER SUPPORT FOUNDATION

YOUR QUITTING PLANS & EXPERIENCES

4. Which of the following best describes your plans for tobacco use at this time? (*check one)*

   ☐ I am a tobacco user and I have decided to quit NOW.

   ☐ I don't know/not sure/ I am not ready to quit.

5. How many times have you tried to quit in the past? *(check one)*

   ☐ None ☐ 1 time ☐ 2 times ☐ 3 or more times

6. How confident are you that you can quit this time? *(Please circle one number between 0 and 10, with 0 being "not at all confident" and 10 being "highly confident.")*

   0 1 2 3 4 5 6 7 8 9 10

   Not at all confident Moderately confident Highly confident

ABOUT YOU

7. What is your date of birth? _______________

8. What is your race?

☐ Caucasian ☐ African American ☐ Native American

☐ Latin American ☐ Asian ☐ Other: ________________

9. Are you male or female? (*check one)*

   ☐ Male

   ☐ Female ➔ are you currently pregnant or breastfeeding? ☐ Yes ☐ No

10. Number of people in your household? __________________

11. Does anyone else in your household smoke?

    ☐ Yes ➔ are they willing to quit smoke too? ☐Yes ☐ No

    ☐ No

12. What is your annual household income?

☐ under 20k ☐ 20k to 49,999 ☐ 50k to 74,999 ☐ 75k to 99,999 ☐ over 100k

Thank you!

UCSF Nicotine Replacement Therapy Agreement

Please fill in all the spaces below and sign your name:

I, (print your name) ___________________________________, am aware of the safe and appropriate use of Nicotine Replacement Therapy (NRT) products. I understand that when using NRT products, I should follow the directions as listed on the product packaging.

(initials)

1. ________ I understand that I should **NOT** use NRT without a physician's approval if I have any of the following medical conditions:

- Younger than 18
- Breastfeeding
- Heart disease
- Irregular hearbeat
- Heart attack or stroke within the last six weeks
- High blood pressure that is not controlled with medication
- Prescription medication for depression or asthma
- Allergic to adhesive tape or have skin problems

2. _______ I will not hold the United Cancer Support Foundation (UCSF) responsible or liable for health consequences related to my used of nicotine replacement therapy.

3. _______ I agree to be contacted by UCSF staff in the time periods (1 week, 4 weeks, 3 months and 5 months after initial **Quit Date**) to follow-up with quitting progress to ensure the effectiveness of the program.

By signing this Waiver, I attest that I have read, understand and agree with the provisions contained herein.

___________________________ ___________________________

Participant Signature Date