UCSF Medical Center
Fontana Tobacco
Treatment Center

Fontana Tobacco Treatment Center Stop Smoking Program

Please complete the following questions and bring this document with you to the first class.

Name_____ Date:_____

Date of birth: _____

Medication allergies: _____

Number of cigarettes you smoke each day: _____

How soon after waking do you smoke your first cigarette? _____minutes

If applicable, please list other forms of tobacco (e.g., cigars, snuff, e-cigarettes) and frequency of use:

_____

What medications prescribed by a doctor do you currently take (please include drug name, strength and directions if known):

_____

_____

_____

Have you ever used a medication to help you stop smoking? ☐ Yes ☐ No

If yes, which of the following (check all that apply):

- ☐ Nicotine patch
- ☐ Nicotine gum
- ☐ Nicotine lozenge
- ☐ Nicotine inhaler
- ☐ Nicotine nasal spray
- ☐ Bupropion SR (Zyban, Wellbutrin)
- ☐ Varenicline (Chantix)
- ☐ Other: _____

Please describe any 'success' with these medications or list any side effects experienced:

_____

_____

Please indicate your daily caffeine intake: _____