ENSP
European Network for Smoking and Tobacco Prevention

Tobacco use screening sheet

Name:..... Age: :.....

Please indicate whether you are a smoker ○ an occasional smoker ○ a nonsmoker ○ a former smoker ○

○ **If you are a nonsmoker,** we would like to thank you for your time and congratulate you that you don't smoke! You are kindly now asked to return this screening sheet to the health personnel of the clinic!

○ **If you are a smoker or an occasional smoker,** please take a few minutes to respond to questions 1-7

○ **If you are a former smoker,** please answer questions 8-14

1. What type of tobacco product do you use? Cigarettes ○ Cigars ○ Pipe ○ Chew ○ Water pipe ○

2. How many years, do you smoke? .....

3. Do you use any novel products? Yes ○ No ○

4. Which type? E-cigarette ○ IQUOS ○ Juul ○ other ○ Please specify .....

5. Fagerstrom Test for nicotine dependence (FTND)

(Please put X in the response that best fits you)	**Score**
1. How soon after you wake up do you smoke the first cigarette? Under 5 minutes (3) ○ 6-30 minutes (2) ○ 31-60 minutes (1) ○ More than 60 minutes (0) ○	.....
2. Does it feel difficult for you to abstain from smoking in places where smoking is banned (e.g. church, cinema, train, restaurant etc.)? Yes (1) ○ No (0) ○	.....
3. Which cigarette would it be the most difficult for you to give up? The first cigarette in the morning (1) ○ All the others (0) ○	.....
4. How many cigarettes/day do you smoke? 10 or fewer (0) ○ 11-20 (1) ○ 21-30 (2) ○ 31 or more (3) ○	.....
5. Do you smoke more frequently in the first hours after you wake up than in the rest of the day? Yes (1) ○ No (0) ○	.....
6. Do you smoke if you are so ill that you are immobilized in bed most of the day? Yes (1) ○ No (0) ○	.....
Total	.....

6. The presence of anxiety or depression

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at All (0)	Several Days (1)	More Than Half the Days (2)	Nearly Every Day (3)	Score
1. Feeling nervous, anxious, or on edge					
2. Not being able to stop or control worrying					.....
3. Feeling down, depressed, or hopeless					
4. Little interest or pleasure in doing things					.....

The Four-Item Patient Health Questionnaire (PHQ–4) for Anxiety and Depression

7. Importance & readiness

1. On a scale from 1 to 10, how important is it for you to quit smoking now?
(not at all important) 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ (very important)
2. On a scale from 1 to 10, are you ready to quit smoking right now?
(not at all ready) 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ (ready)

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If you are a former smoker, please take a few minutes to respond to the following:

8. How many cigarettes did you use to smoke before quitting? .....

9. How soon after you woke up did you use to smoke the first cigarette?
Under 5 minutes ..... ○
6-30 minutes..... ○
31-60 minutes..... ○
More than 60 minutes..... ○

10. How many cigarettes/day did you smoke?
10 or fewer ..... ○
11-20 (1) ..... ○
21-30 (2) ..... ○
31 or more (3)..... ○

11. For how long have you been abstinent? .....

12. Do you experience any withdraw symptoms? ..... Yes ○ No ○

13. Taking any medication to quit smoking?..... Yes ○ No ○
If yes,
What treatment do/did you use?
NRT..... ○
Please specify the type/s of NRT you were using .....
Varenicline ..... ○
Bupropion ..... ○
Other..... ○
Please specify.....
Do/Did you experience any side effects from medication?
Yes ○ No ○ If yes, Please specify.....

14. Have you any thoughts of going back to smoking?..... Yes ○ No ○

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