

# Tobacco Use Survey

Date of Activity: \_\_\_\_\_ Visit for Caregiver/Adult or Child? (select one) Caregiver/Adult or Child

Which Caregiver/Adult or Child was involved: \_\_\_\_\_ ID#: \_\_\_\_\_

Please look at all three sections and answer all that apply.

## Section A

**Please check the answer that best describes you:**

PREGNANT	NOT PREGNANT
<input type="checkbox"/> I have <b>NEVER</b> smoked or have smoked less than 100 cigarettes in my lifetime.	<input type="checkbox"/> I have <b>NEVER</b> smoked or have smoked less than 100 cigarettes in my lifetime.
<input type="checkbox"/> I <b>STOPPED</b> smoking <b>BEFORE</b> I found out I was pregnant.	<input type="checkbox"/> I <b>STOPPED</b> smoking in the past <b>ONE YEAR</b> .
<input type="checkbox"/> I <b>STOPPED</b> smoking <b>AFTER</b> I found out I was pregnant, and I am not smoking now.	<input type="checkbox"/> I <b>STOPPED</b> smoking <b>OVER ONE YEAR AGO</b> .
<input type="checkbox"/> I smoke <b>SOME NOW</b> , but I <b>CUT DOWN, SINCE</b> I found out I was pregnant.	<input type="checkbox"/> I <b>CURRENTLY</b> smoke on a <b>LESS THAN DAILY</b> basis.
<input type="checkbox"/> I smoke <b>REGULARLY NOW</b> , and have <b>NOT CUT DOWN</b> since I found out I was pregnant.	<input type="checkbox"/> I <b>CURRENTLY</b> smoke on a <b>DAILY</b> basis.
Do you use electronic cigarettes or E-cigarettes? <input type="checkbox"/> yes <input type="checkbox"/> no	
Do you use smokeless tobacco products? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what kind of smokeless tobacco product do you use? _____	

## Section B

**Second Hand Smoke Exposure:**

1. How many smokers do you live with? _____
2. What is your relationship to the above smoker(s)? ( <i>check all that apply</i> ) <input type="checkbox"/> partner <input type="checkbox"/> parent <input type="checkbox"/> friend <input type="checkbox"/> other _____
3. How often does anyone smoke inside your home or car? Would you say: <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> less than monthly <input type="checkbox"/> never

## Section C

**If you smoke:**

1. If you smoke, in the last 30 days, how often did you smoke? <input type="checkbox"/> every day <input type="checkbox"/> some days
2. On an average day that you smoke, about how many cigarettes do you currently smoke? (by cigarette, we would like you to include cigarettes, e-cigarettes, cigars, or cigarillos like black and tans) # _____
3. Are you interested in quitting smoking? <input type="checkbox"/> yes, in the next 30 days <input type="checkbox"/> yes, but not now <input type="checkbox"/> I'm not interested in quitting

This survey was adapted, with permission, from the Clean Air for Healthy Children and Families [www.cleanairforhealthychildren.org](http://www.cleanairforhealthychildren.org), [cafhc@paaaap.org](mailto:cafhc@paaaap.org). Adaptations include questions from the American Academy of Pediatrics (AAP) <http://www.2aap.org/ricmondcenter/SHSExposure.html> and Centers for Disease Control [http://www.who.int/tobacco/surveillance/en\\_tfi\\_tqs.pdf](http://www.who.int/tobacco/surveillance/en_tfi_tqs.pdf). Survey adaptations made by the Kansas Department of Health and Environment (KDHE) Bureau of Family Health, Smoking Cessation Workgroup, for the Collaborative Improvement & Innovation Network (CoIN) to Reduce Infant Mortality, with consult by the Department of Preventive Medicine and Public Health at the Kansas University Medical Center.