

**NAME:** \_\_\_\_\_

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**PLEASE CIRLE ANSWERS**

**DO YOU SMOKE:** YES / NO    **FORMER SMOKER:** YES / NO

**YEARS SMOKED:** \_\_\_\_ **START YEAR:** \_\_\_\_ **END YEAR**(if former smoker): \_\_\_\_

**IF YOU SMOKE/SMOKED, WHEN DID YOU LAST SMOKE:** \_\_\_\_\_

**HOW MANY PACKS PER DAY:** \_\_\_\_\_ **YEARS SMOKED:** \_\_\_\_\_

**DO YOU SMOKE CIGARS:** YES / NO    **CHEW TOBACCO:** YES / NO

**USE SNUFF:** YES / NO

**DO YOU DRINK ALCOHOL:** YES / NO

**IF YOU DRINK ALCOHOL, HOW OFTEN DID YOU HAVE A DRINK  
CONTAINING ALCOHOL IN THE PAST YEAR?**

NEVER                      MONTHLY OR LESS                      2-4 TIMES A MONTH  
2-3 TIMES A WEEK                      4 OR MORE TIMES A WEEK

**HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY  
WHEN YOU WERE DRINKING IN THE PAST YEAR?**

1-2 DRINKS    3-4 DRINKS    5-6 DRINKS    7-9 DRINKS    10+ DRINKS

**HOW OFTEND DID YOU HAVE 6 OR MORE DIRINKS ON ONE  
OCCASION IN THE PAST YEAR?**

NEVER                      LESS THAN A MONTHLY                      MONTHLY  
WEEKLY                      DAILY OR ALMOST DAILY

