# Help Your Patients Quit Smoking

NYC Health

*Document status at every visit* Date: _____

**Smoking Status (check all that apply)**

- ☐ Current Smoker (#_____cigarettes per day/week)
- ☐ Never Smoked
- ☐ Former Smoker (30 days smoke-free) (#_____weeks/years quit)
- ☐ Other Smokers in Home
- ☐ Pregnant

**Smoking Cessation (check all that apply)**

- ☐ Brief Counseling
- ☐ Cessation Referral
- ☐ Not Ready to Quit
- ☐ Rx (medication) _____

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**Follow-Up Date** _____