SMOKE-FREE FAMILIES CORE SCREENING FORM
(1 page only)

ID #: _____ Date: _____/_____/_____
(mo) (day) (yr)

1. When is your baby due? (*If not known, go to Question 1a)* _____/_____/_____
(mo) (day) (yr)

1a. How many weeks has it been since your last period? _____ weeks

2. What is your birth date? _____/_____/_____
(mo) (day) (yr)

3. Which of the following groups best describes your race? (Please circle one)

1. American Indian or Alaska Native **2.** Asian **3.** Black or African American

4. Native Hawaiian or Other Pacific Islander **5.** White

4. Are you a person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin regardless of your race? (*Please circle one)*

1. Yes **2.** No

5. What is your marital status? (*Please circle one)*

1. Married and living with a partner

2. Not married and living with partner

3. Widowed, divorced or separated and not living with partner

4. Never married and not living with a partner

6. Which statement best describes you now? (*Please check one)*

____ **1.** I smoke regularly now, about the same as **BEFORE** I found out I was pregnant.

____ **2.** I smoke regularly now, but more than **BEFORE** I found out I was pregnant.

____ **3.** I smoke some now, but I cut down on the number of cigarettes I smoke **SINCE** I found out I was pregnant.

____ **4.** I stopped smoking **AFTER** I found out I was pregnant, and I am not smoking now.

____ **5.** I stopped smoking **BEFORE** I found out I was pregnant, and I am not smoking now.

____ **6.** I have **NEVER** smoked, or I have smoked **LESS THAN** 100 cigarettes ever.

7. Have you smoked a cigarette, even a puff, within the last 30 days? (*Please circle one*)

1. Yes (*If you answered "Yes," go to Question 8*) **2.** No (*If you answered "No," STOP HERE*)

8. Have you smoked a cigarette, even a puff, within the last 7 days? (*Please circle one*)

1. Yes **2.** No

FOR SMOKERS ONLY
SMOKE-FREE FAMILIES CORE BASELINE ASSESSMENT FORM

ID #: _____ Date: _____/_____/_____
(mo) (day) (yr)

1. Are you seriously thinking about quitting smoking completely during this pregnancy? (*Please circle one.)*

1. Yes **2.** No (*If "No," skip to questions 3.)*

2. Are you planning to quit smoking completely within the next 30 days? (*Please circle one.)*

1. Yes **2.** No

3. **BEFORE** you found out you were pregnant, how many cigarettes did you usually smoke each day?

_____ cigarettes

4. **SINCE** you found out you were pregnant, how many times did you quit smoking and stay quit for at least 24 hours?

_____ times

5. During the past 7 days, how many cigarettes did you usually smoke each day?

_____ cigarettes

6. **SINCE** you found out that you were pregnant, how soon after you wake up do you usually smoke your first cigarette? (*Please circle one.)*

1. less than 5 minutes **3.** 31 to 59 minutes **5.** greater than 2 hours

2. 6 to 30 minutes **4.** 1 to 2 hours

7. How much would you say you want to **STOP** smoking? (*Please circle one.)*

1	**2**	**3**	**4**
not at all	not much	some	a lot

8. How much would you say you want to **KEEP** smoking? (*Please circle one*.)

1	**2**	**3**	**4**
not at all	not much	some	a lot

9. If you decided to quit smoking during the next month, how confident are you that you could do it? (*Please circle one.)*

1	**2**	**3**	**4**
not at all	not very	somewhat	very

10. How much do you think that cigarette smoking can harm your unborn child's health? *(Please circle one.)*

1	**2**	**3**	**4**
not at all	not much	some	a lot

11. How much do you think that cigarette smoking can harm your health? *(Please circle one.)*

1	**2**	**3**	**4**
not at all	not much	some	a lot

12. How many of your family members and friends whom you see regularly are cigarette smokers? *(Please circle one.)*

1	**2**	**3**	**4**
none	few	some	most

13. How many cigarette smokers, **NOT INCLUDING YOURSELF**, live in your home?

_____ smokers

14. How is cigarette smoking handled in your home. (*Please circle one.)*

1. No one is allowed to smoke in my home

2. Only special guests are allowed to smoke in my home

3. People are allowed to smoke only in certain areas in my home

4. People are allowed to smoke anywhere in my home

15. If you tried to quit smoking, how much support or understanding do you think you would get from family, friends, and coworkers? (*Please circle one.)*

1	**2**	**3**	**4**
none	not much	some	a lot

16. Have you ever had any of the following feelings nearly every day for two or more weeks at a time: down, depressed, hopeless, little interest or pleasure in doing things? *(Please circle yes or no.)*

1. Yes **2.** No

17. How much of the time, during the past month, have you felt downhearted and blue? *(Please circle one.)*

1	**2**	**3**	**4**
never	some	a lot	all

18. What is the total number of years of school that you have completed? (*Include elementary, high school, college, and graduate school. If you received a GED, you should count that as 12 years.)*

_____ years

19. How old were you when you first started smoking cigarettes regularly? (That is, you usually smoked some every week.)

_____ years old

20. How many births (at 20 weeks or 5 months or more) have you had? *(If this is your first pregnancy, your answer should be "0.")*

_____ births

21. Medical bills can be paid in many ways. When you made a visit to a doctor or clinic for prenatal care, how was the bill paid? *(Please circle **all** that apply)*

1. I paid for it myself
2. Parents or other relatives
3. Private insurance
4. Medicaid
5. Champus
6. Some other way *(Specify)*

_____

FOR SMOKERS ONLY
SMOKE-FREE FAMILIES CORE END-OF-PREGNANCY ASSESSMENT FORM

ID #:_____ Date: _____/_____/_____
(mo) (day) (yr)

1. Have you smoked a cigarette, even a puff, **WITHIN THE LAST 30 DAYS**? (*Please circle one*)

1. Yes **2.** No

2. Have you smoked a cigarette, even a puff, **WITHIN THE LAST 7 DAYS**? *(Please circle one)*

1. Yes **2.** No

3. **DURING THE PAST 7 DAYS**, how many cigarettes did you usually smoke each day? (If none, please put "0.")

_____ cigarettes

4. **AFTER** your first prenatal visit, how many times did you quit smoking for at least 24 hours? (Do not include "quits" because of hospitalization.)

_____ times

5. **AFTER** your first prenatal visit, about how many weeks were you able to stay off cigarettes (that is, you did not smoke a cigarette, even a puff, during a 7-day period)?

_____ weeks

6. If still smoking, how soon after you wake up do you usually smoke your first cigarette? *(Please circle one)*

1. I am not currently smoking
2. 5 minutes or less
3. 6 to 30 minutes
4. 31 to 59 minutes
5. 1 to 2 hours
6. greater than 2 hours

7. How many of your family members and friends whom you see regularly are cigarette smokers? *(Please circle one)*

1	**2**	**3**	**4**
none	few	some	most

8. How many cigarette smokers, **NOT INCLUDING YOURSELF**, live in your home?

_____ smokers

9. How is cigarette smoking handled in your home? *(Please circle one)*

1. No one is allowed to smoke in my home
2. Only special guests are allowed to smoke in my home
3. People are allowed to smoke only in certain areas in my home
4. People are allowed to smoke anywhere in my home

10. If you decided to quit smoking, how much support or understanding would you expect to get from family, friends, or co-workers to help you quit? (*Please circle one)*

1	**2**	**3**	**4**
none	not much	some	a lot

11. During the past month, how much of the time, have you felt downhearted and blue? *(Please circle one)*

1	**2**	**3**	**4**
none	not much	a lot	all

12. Medical bills can be paid in many ways. When you made a visit to a doctor or clinic for prenatal care, how was the bill paid? *(Please circle **all** that apply)*

1. I paid for it myself

2. Parents or other relatives

3. Private Insurance

4. Medicaid

5. Champus

6. Some other way (*Specify*)

_____

13. Since you started prenatal care, has any member of the clinic staff **TALKED** with you about your trying to quit smoking? (*Please circle one*)

1. Yes **2.** No

14. How useful was the **ADVICE OR COUNSELING** you received from clinic staff in helping you try to quit smoking? (*Please circle one*)

1. Did not receive advice or counseling	**2.** Not useful at all	**3.** Not very useful	**4.** Somewhat useful	**5.** Very useful

15. Since you started prenatal care has, any member of the clinic staff given you **QUIT-SMOKING MATERIALS**? (*Please circle one)*

1. Yes **2.** No

16. How useful were the **MATERIALS** you received from clinic staff in helping you try to quit smoking? (*Please circle one*)

1. Did not receive any materials	**2.** Not useful at all	**3.** Not very useful	**4.** Somewhat useful	**5.** Very useful

17. <u>OTHER THAN</u> THE SMOKING-RELATED GUIDE/VIDEO/MATERIALS/ADVICE PROVIDED AS PART OF YOUR PRENATAL CARE, have you done any of the following to help you try to quit or stay off cigarettes: (*Please circle "Yes" or "No" for each*)

17a. Participated in a group quit-smoking program or clinic?

1. Yes (Please specify): _____ **2.** No

17b. Participated in a group program such as Lamaze, Childbirth Education for Parenthood that included "quit-smoking" advice?

1. Yes (Please specify): _____ **2.** No

17c. Participated in a one-to-one quit-smoking program with personal counseling or support?

1. Yes (Please specify): _____ **2.** No

17d. Used a quit-smoking guide or video with personal counseling or support?

1. Yes (Please specify): _____ **2.** No

17e. Used nicotine gum?

1. Yes (Please specify): _____ **2.** No

17f. Used nicotine skin patches?

1. Yes (Please specify): _____ **2.** No

17g. Tried hypnosis?

1. Yes (Please specify): _____ **2.** No

17h. Tried acupuncture?

1. Yes (Please specify): _____ **2.** No

17i. Tried other methods

1. Yes (Please specify): _____ **2.** No

18. When is your baby due? _____/_____/_____
(mo) (day) (yr)

FOR SMOKERS ONLY
SMOKE-FREE FAMILIES CORE POSTPARTUM ASSESSMENT FORM

ID #: _____ Date: _____/_____/_____
(mo) (day) (yr)

1. Have you smoked a cigarette, even a puff, WITHIN THE LAST 30 DAYS? (*Circle one*)

1. Yes **2.** No

2. Have you smoked a cigarette, even a puff, WITHIN THE LAST 7 DAYS? (*Circle one*)

1. Yes **2.** No

3. **DURING** THE PAST 7 DAYS, how many cigarettes did you usually smoke each day?
(*If none, your answer should be "0."*)

_____ cigarettes

4. How much do you think that cigarette smoking can harm your infant's health? (*Circle one*)

1	**2**	**3**	**4**
not at all	a little	some	a lot

5. How is cigarette smoking handled in your home? (*Circle one*)

1. No one is allowed to smoke in my home

2. Only special guests are allowed to smoke in my home

3. People are allowed to smoke only in certain areas in my home

4. People are allowed to smoke anywhere in my home

6. Has your baby's doctor or nurse ever talked with you about the importance of not smoking around your baby? (*Circle one*)

1. Yes **2**. No

7. During the past month, how much of the time have you felt downhearted and blue? (*Circle one*)

1	**2**	**3**	**4**
never	some	a lot	all

8. When was your baby born? Date (month, day, year): _____

9. How much did your baby weigh at birth? _____ pounds, _____ ounces