*NAME OF PATIENT:* ____________________ *DATE:* __________

***ADVANCED PAIN CENTERS***
***SMOKING ADDICTION***
***PATIENT DIARY***

| Date | DID YOU SMOKE | If Yes Indicate Frequency by Time Period . Also indicate any side effects |
|---|---|---|
| | ☐ NO ☐ YES | ☐ Early AM # Cigarettes ______ ☐ Mid Morning # Cigarettes ______<br>☐ Afternoon # Cigarettes ______ ☐ Evening # Cigarettes ______<br>Side Effects: |
| | ☐ NO ☐ YES | ☐ Early AM # Cigarettes ______ ☐ Mid Morning # Cigarettes ______<br>☐ Afternoon # Cigarettes ______ ☐ Evening # Cigarettes ______<br>Side Effects: |
| | ☐ NO ☐ YES | ☐ Early AM # Cigarettes ______ ☐ Mid Morning # Cigarettes ______<br>☐ Afternoon # Cigarettes ______ ☐ Evening # Cigarettes ______<br>Side Effects: |
| | ☐ NO ☐ YES | ☐ Early AM # Cigarettes ______ ☐ Mid Morning # Cigarettes ______<br>☐ Afternoon # Cigarettes ______ ☐ Evening # Cigarettes ______<br>Side Effects: |
| | ☐ NO ☐ YES | ☐ Early AM # Cigarettes ______ ☐ Mid Morning # Cigarettes ______<br>☐ Afternoon # Cigarettes ______ ☐ Evening # Cigarettes ______<br>Side Effects: |
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