

Attachment 2e

**PATH Study Data Collection Instruments:
Tobacco Use Form**

July 23, 2012

Have you used any of the following products today, yesterday, or the day before yesterday?

(If you don't know an answer or don't want to provide one, you may leave the question blank.)

<p>1 Cigarettes?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last smoke a cigarette?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last smoke a cigarette?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last smoked a cigarette, how many did you smoke?</p> <p><input type="text"/> <input type="text"/></p>
<p>2 E-cigarettes?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last use an e-cigarette?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last use an e-cigarette?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last used an e-cigarette, how many times did you use it?</p> <p><input type="text"/> <input type="text"/></p>
<p>3 Cigars?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last smoke a cigar?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last smoke a cigar?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last smoked a cigar, how many did you smoke?</p> <p><input type="text"/> <input type="text"/></p>
<p>4 Cigarillos?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last smoke cigarillos?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last smoke cigarillos?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last smoked cigarillos, how many did you smoke?</p> <p><input type="text"/> <input type="text"/></p>
<p>5 Little filtered cigars?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last smoke little filtered cigars?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last smoke little filtered cigars?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last smoked little filtered cigars, how many did you smoke?</p> <p><input type="text"/> <input type="text"/></p>
<p>6 Regular pipe filled with tobacco?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last smoke a regular pipe filled with tobacco?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last smoke a regular pipe filled with tobacco?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last smoked a regular pipe filled with tobacco, how many bowls did you smoke?</p> <p><input type="text"/> <input type="text"/></p>
<p>7 Hookah?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last smoke a hookah?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last smoke a hookah?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last smoked a hookah, how many times did you smoke it?</p> <p><input type="text"/> <input type="text"/></p>
<p>8 Snus pouches?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last use snus pouches?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last use snus pouches?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last used snus pouches, how many did you use?</p> <p><input type="text"/> <input type="text"/></p>
<p>9 Smokeless tobacco (such as chew, snuff, or dip)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>When did you last use smokeless tobacco?</p> <p><input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday</p> <p><input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday</p>	<p>What time of day did you last use smokeless tobacco?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Evening</p> <p><input type="checkbox"/> Afternoon</p>	<p>During the day you last used smokeless tobacco, how many times did you use it?</p> <p><input type="text"/> <input type="text"/></p>

PATH Study Tobacco Use Form

Have you used any of the following products today, yesterday, or the day before yesterday?

(If you don't know an answer or don't want to provide one, you may leave the question blank.)

10 Dissolvable tobacco?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last use dissolvable tobacco? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last use dissolvable tobacco? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last used dissolvable tobacco, how many pieces did you use?	<input type="text"/> <input type="text"/>
11 Nicotine patch?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last use a nicotine patch? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last use a nicotine patch? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last used a nicotine patch, how many did you use?	<input type="text"/> <input type="text"/>
12 Nicotine gum?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last use nicotine gum? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last use nicotine gum? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last used nicotine gum, how many pieces did you use?	<input type="text"/> <input type="text"/>
13 Nicotine inhaler?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last use a nicotine inhaler? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last use a nicotine inhaler? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last used a nicotine inhaler, how many times did you use it?	<input type="text"/> <input type="text"/>
14 Nicotine nasal spray?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last use a nicotine nasal spray? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last use a nicotine nasal spray? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last used a nicotine nasal spray, how many times did you use it?	<input type="text"/> <input type="text"/>
15 Nicotine lozenge or pill?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last use a nicotine lozenge or pill? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last use a nicotine lozenge or pill? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last used a nicotine lozenge or pill, how many times did you use it?	<input type="text"/> <input type="text"/>
16 Prescription drug to stop smoking? (such as Chantix, varenicline, Wellbutrin, Zyban, or bupropion)	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	When did you last take a prescription drug to stop smoking? <input type="checkbox"/> In the past hour <input type="checkbox"/> Yesterday <input type="checkbox"/> Sometime today <input type="checkbox"/> Day before yesterday	What time of day did you last take a prescription drug to stop smoking? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon	During the day you last took a prescription drug to stop smoking, how many did you take?	<input type="text"/> <input type="text"/>

Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (XXXX-XXXX). Do not return the completed form to this address.

Date: / / **20**

Time: : AM PM

Participant ID: _____