

Section 3A - TOBACCO USE

Statement I

Now I'd like to ask you about your experiences with tobacco.

1a. In your ENTIRE LIFE, have you ever . . . Smoked at least 100 cigarettes?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Smoked at least 50 cigars?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Smoked a pipe at least 50 times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d. Used snuff, such as Skoal, Skoal Bandit or Copenhagen at least 20 times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. Used chewing tobacco, such as Redman, Levi Garrett or Beechnut at least 20 times?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

CHECK ITEM 3.1	Is at least 1 category marked in a - e above?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i>
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For each tobacco category reported in 1, MARK EACH TOBACCO CATEGORY CODE BOX and ask 2 through 7 for each tobacco category marked.	1 <input type="checkbox"/> Cigarettes	2 <input type="checkbox"/> Cigars	3 <input type="checkbox"/> Pipe	4 <input type="checkbox"/> Snuff	5 <input type="checkbox"/> Chewing Tobacco
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2a. (About how old were you when you smoked your first FULL (cigarette/cigar/pipe bowl of tobacco)?/About how old were you when you first used snuff/chewing tobacco?)	___ Age				
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3a. When was the MOST RECENT time you (smoked a/used) (Name of tobacco category)? If DK, then ask: Was it within the past year?	___ Hour(s) ago OR ___ Day(s) ago OR ___ Week(s) ago OR ___ Month(s) ago OR ___ Year(s) ago	___ Hour(s) ago OR ___ Day(s) ago OR ___ Week(s) ago OR ___ Month(s) ago OR ___ Year(s) ago	___ Hour(s) ago OR ___ Day(s) ago OR ___ Week(s) ago OR ___ Month(s) ago OR ___ Year(s) ago	___ Hour(s) ago OR ___ Day(s) ago OR ___ Week(s) ago OR ___ Month(s) ago OR ___ Year(s) ago	___ Hour(s) ago OR ___ Day(s) ago OR ___ Week(s) ago OR ___ Month(s) ago OR ___ Year(s) ago
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CHECK ITEM 3.2	Did respondent (smoke/use) (tobacco product) in the last year? <i>Refer to 3a, if necessary.</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
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3b. (SHOW FLASHCARD 21) About how often did you USUALLY (smoke/use) (Name of tobacco category) (in the past year/in the year right before you stopped)?	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less	1 <input type="checkbox"/> Every day - SKIP to 5 2 <input type="checkbox"/> 5 to 6 days a week 3 <input type="checkbox"/> 3 to 4 days a week 4 <input type="checkbox"/> 1 to 2 days a week 5 <input type="checkbox"/> 2 to 3 days a month 6 <input type="checkbox"/> Once a month or less
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		1 <input type="checkbox"/> Cigarettes	2 <input type="checkbox"/> Cigars	3 <input type="checkbox"/> Pipe	4 <input type="checkbox"/> Snuff	5 <input type="checkbox"/> Chewing Tobacco
3c.	(On the days that you smoked (in the past year/ in the year right before you stopped), about how many (cigarettes/cigars/ pipe bowls of tobacco) did you USUALLY smoke?/ On the days that you used (snuff/chewing tobacco) (in the past year/in the year right before you stopped) about how many (pinches, dips or rubs/plugs, wads or chews) did you use?)	____ Number	____ Number	____ Number	____ Number	____ Number
d.	For how long (have/did) you (smoke(d)/use(d)) this amount?	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)			
4.	Did you ever (smoke/use) (Name of tobacco category) every day?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to Check Item 3.3	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to 8a, page 35
5.	About how old were you when you FIRST started (smoking/using) (Name of tobacco category) every day?	____ Age	____ Age	____ Age	____ Age	____ Age
6.	Thinking back over the entire period when you were (smoking/using snuff/ chewing tobacco) every day, about how many (cigarettes/cigars/pipe bowls of tobacco/pinches, dips or rubs/plugs, wads or chews) did you USUALLY (smoke/use) in a single day?	____ Number	____ Number	____ Number	____ Number	____ Number
7.	For how long (have/did) you (smoke(d)/use(d)) this amount every day?	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)	____ Day(s) OR ____ Week(s) OR ____ Month(s) OR ____ Year(s)			
CHECK ITEM 3.3	Is another tobacco category marked?	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	1 <input type="checkbox"/> Yes - Fill 2-7 in designated column for next tobacco category 2 <input type="checkbox"/> No - Go to Check Item 3.3A	
CHECK ITEM 3.3A	Are all columns in Check Item 3.2 marked "No"?	1 <input type="checkbox"/> Yes - Ask 8a and c only 2 <input type="checkbox"/> No - Ask 8a, b and c as appropriate				

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8a. The next few questions are about experiences that many people have had with using tobacco, including cigarettes, cigars, a pipe, snuff or chewing tobacco. As I read each experience, please tell me if it has EVER happened to you as a result of using ANY of these types of tobacco.

b. Did this happen in the last 12 months?

c. Did this happen before 12 months ago, that is before last (Month one year ago)?

In your ENTIRE LIFE, did you EVER ... (PAUSE)
(Repeat phrase frequently)

(1) More than once want to stop or cut down on your tobacco use?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) Give up or cut down on activities that you were interested in or that gave you pleasure because tobacco use was not permitted at the activity?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(3) Give up or cut down on activities that were important to you - like associating with friends or relatives or attending social activities because tobacco use was not permitted at the activity?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(4) Continue to use tobacco even though you knew it was causing you a health problem or making a health problem worse?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(5) Find yourself (chain smoking/using one pinch or plug of snuff or chewing tobacco right after another)?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(6) More than once try to stop or cut down on your tobacco use but found you couldn't do it?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(7) Many people experience problems on occasions when they stop or cut down on their tobacco use. After stopping or cutting down on your tobacco use, did you EVER...			
(a) Feel depressed?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(b) Have difficulty falling asleep or staying asleep?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(c) Have difficulty concentrating?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience, page 36</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

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8a. In your ENTIRE LIFE, did you EVER ... (PAUSE) <i>(Repeat phrase frequently)</i>		b. Did this happen in the last 12 months?	c. Did this happen before 12 months ago, that is before last (Month one year ago)?
(d) Eat more than usual or gain weight?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(e) Become easily irritated, angry, or frustrated?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(f) Feel anxious or nervous?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(g) Feel your heart beating more slowly than usual?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(h) Feel more restless than usual?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Check Item 3.4</i>	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Mark "Yes" in column c</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 3.4	Are at least 2 items marked "Yes" in column b, 7(a) – 7(h)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.5</i>	
(i) You just mentioned that you had some experiences after stopping or cutting down on your tobacco use in the last 12 months. Were any of these experiences very uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(j) Did you use tobacco in the last 12 months to keep from having any of these experiences?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
CHECK ITEM 3.5	Are at least 2 items marked "Yes" in column c, 7(a) - 7(h)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to (8), page 37</i>	
(k) You just mentioned that you had some experiences after stopping or cutting down on your tobacco use BEFORE 12 months ago. Were any of these experiences very uncomfortable or upsetting to you or did they cause problems in your life - like at work or school or with family or friends?			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

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8a. In your ENTIRE LIFE, did you EVER ... (PAUSE) <i>(Repeat phrase frequently)</i>	b. Did this happen in the last 12 months?	c. Did this happen before 12 months ago, that is before last (Month one year ago)?
(1) Did you use tobacco to keep from having any of these experiences before 12 months ago?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(8) Wake up in the middle of the night to use tobacco?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(9) Often use tobacco just after getting up or shortly after getting up in the morning?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(10) Find yourself using tobacco JUST AFTER being in a situation where tobacco use was not permitted - like after being on a plane, at a meeting, or shopping at the mall?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(11) Find that you had to use much more tobacco than you once did to get the effect you wanted?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(12) Increase your use of tobacco by at least 50 percent?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(13) Have a period when you often used tobacco more than you intended to?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to next experience</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(14) Continue to use tobacco even though it made you nervous, jittery, anxious or depressed?	1 <input type="checkbox"/> Yes —————→ 2 <input type="checkbox"/> No - <i>Go to Check Item 3.6</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
CHECK ITEM 3.6 Is more than 1 item marked in 1(a) - (e), page 33?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.8</i>	
CHECK ITEM 3.7 Are at least 3 Boxes marked in 8, column b, pages 35 - 36?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Check Item 3.8</i>	
9. What type or types of tobacco were you using when you had some of these experiences with tobacco you mentioned in the last 12 months? <i>Mark (X) all that apply.</i>	1 <input type="checkbox"/> Cigarettes 2 <input type="checkbox"/> Cigars 3 <input type="checkbox"/> Pipe 4 <input type="checkbox"/> Snuff 5 <input type="checkbox"/> Chewing tobacco	
CHECK ITEM 3.8 Are at least 3 Boxes marked "Yes" in 8, column c, pages 35 - 36?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i>	
10a. You just mentioned some experiences with using tobacco that happened in the past, that is, before 12 months ago. Now I'd like to know if some of the experiences you mentioned happened around the same time in the past. Before last (Month one year ago), was there EVER a period when SOME of these experiences were happening around the same time most days FOR AT LEAST A MONTH?	1 <input type="checkbox"/> Yes - <i>SKIP to 10d, page 38</i> 2 <input type="checkbox"/> No	

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<p>10b. Before last (<i>Month one year ago</i>), was there EVER a period when SOME of these experiences were happening around the same time ON AND OFF FOR A FEW MONTHS OR LONGER?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 10d</i> 2 <input type="checkbox"/> No</p>
<p>c. Before last (<i>Month one year ago</i>), was there EVER a time when some of these experiences happened within the same 1-year period?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i></p>
<p>d. About old were you the FIRST time SOME of these experiences BEGAN to happen at around the same time?</p>	<p>_____ Age</p>
<p>e. In your entire LIFE, how many separate periods like this did you have when some of these experiences were happening around the same time?</p> <p>By separate periods, I mean times that were separated by at least 1 year when you STOPPED using tobacco entirely OR you didn't have any of the experiences you mentioned with tobacco at all?</p>	<p>_____ Number</p>
<p>CHECK ITEM 3.9A Is number entered in 10e, 2 or more or unknown?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 10h</i></p>
<p>10f. What was the longest period you had when SOME of these experiences were happening around the same time?</p>	<p>_____ Month(s) OR _____ Year(s)</p>
<p>g. How old were you the MOST RECENT time SOME of these experiences BEGAN to happen at around the same time?</p>	<p>_____ Age - <i>SKIP to Check Item 3.9B</i></p>
<p>h. How long did this period last when SOME of these experiences were happening around the same time?</p>	<p>_____ Month(s) OR _____ Year(s)</p>
<p>CHECK ITEM 3.9B Is at least 1 item marked in 8, column b, pages 35 - 36?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 3.9C</i> 2 <input type="checkbox"/> No</p>
<p>10i. About how old were you when you FINALLY STOPPED having any of these experiences with tobacco? By finally stopped, I mean they never started happening again.</p>	<p>_____ Age</p>
<p>CHECK ITEM 3.9C Is "Yes" marked in Check Item 3.6?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to Section 3B, page 39</i></p>
<p>11. What type or types of tobacco were you using when you had some of the experiences you mentioned with tobacco BEFORE 12 months ago?</p> <p><i>Mark (X) all that apply.</i></p>	<p>1 <input type="checkbox"/> Cigarettes 2 <input type="checkbox"/> Cigars 3 <input type="checkbox"/> Pipe 4 <input type="checkbox"/> Snuff 5 <input type="checkbox"/> Chewing tobacco</p>