CONFIDENTIAL

SMOKING ASSESSMENT QUESTIONNAIRE

*Please complete this questionnaire **before** you attend your first stop smoking session*. If you have problems with any questions we will go through this with you.

Personal Details

Full Name:……

Address:……

……

……Postcode: ……

Telephone No: ……

Date of birth:……Age……

Next of kin details: Name: ……

Telephone No: ……

GP & Surgery Details

GP's Name: ……

Address:……

……

……Postcode: ……

Telephone No: ……

Stopping Smoking Details

1. Are you male or female?

   Male ☐ Female ☐

2. Which one of the following best describes your ethnic origin?

A. White

☐ British

☐ Irish

☐ Any other white background

(please state)…….

B. Mixed

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Any other mixed background

(please state)……

C. Asian or Asian British

□ Indian

□ Pakistani

□ Bangladeshi

□ Chinese

□ Any other Asian background

(please state)…….

D. Black or Black Asian

□ Caribbean

□ African

□ Any other Black background

(please state)……

E. Other ethnic group

□ Any other ethnic group

(please state)……

3. How did you hear about the service?

   GP ☐ Health Professional ☐ Poster/Leaflet Advert ☐ National Health Line ☐

   Self Referral ☐ Other ☐ Please specify ……

4. How long have you been a smoker? ……..

5. What are the main reasons for wanting to stop smoking?.....

   ……...

6. How many times have you seriously tried to stop smoking in the last 5 years?

   ……..

7. What is the longest period of time you have managed to go without a puff of a cigarette?

   ……..

8. If you have managed to stop smoking in the past what do you think helped?.....

   ……

9. What do you feel was the main reason that you started again?.....

   ……

10. Have you ever used Nicotine therapy in the past? (please tick all that apply)

Gun ☐ Patch ☐ Nasal Spray ☐ Microtab ☐ Inhalator ☐ Lozenges ☐ None ☐

11. How many cigarettes do you smoke per day?.....

12. What do you think are the main reasons that you smoke?.....

.....

13. How soon after waking do you have your first cigarette? (please tick box)

Less than 5 minutes ☐ Between 5-15 minutes ☐

Between 15-30 minutes ☐ Between 30-60 minutes ☐

Between 1-2 hours ☐ Over 2 hours ☐

14. On a scale of 1-10, how confident are you that if you tried, you could give up smoking? 1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

15. On a scale of 1-10, how motivated are you to stop smoking? (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

16. Have you ever suffered from any of the following health problems?

Health Problem	**Yes**	**No**	**Comments**
Heart Disease			
Cancer			
Stroke			
Chronic Bronchitis/Emphysema			
Chronic Cough			
Asthma			
Stomach or Duodenal Ulcer			
Epilepsy, Seizures or Fits			
Previous Head Injury			
Brain Tumour			
Eating Disorders			
Liver Disease			
Manic-Depression Disorder			
Kidney Disease or Dysfunction			
Alcohol problem			
High Blood Pressure			
Other			

17. Have you suffered from any other problem with your health that has not been mentioned?

……..

18. Are you currently pregnant or planning to become pregnant (if applicable) ?.....

……

19. Are you breast-feeding (if applicable) ?.....

20. Do you drink alcohol?.....Yes□ No□

21. If yes, how much alcohol do you drink in an average week?.....

……

22. Are you currently taking any prescribed medication?

……

……

Informed Consent:

I understand that information relating to my attempt to stop smoking will be kept securely by East Surrey Stop Smoking Service fro no more than 18 months after the end of the group and I agree that the Stop Smoking Services may:

a) Contact me for follow up support approximately 6 and 12 months after the end of the group

Yes□ No□

b) Inform my general practitioner of my progress with stopping smoking

Yes□ No□

Signature

Date

Thank you for taking the time to complete this questionnaire.

The information you have provided is strictly confidential, and for staff use only. Some information e.g. age, sex, ethnicity is required by the Department of Health for monitoring our service. Other information will be used to help guide your treatment.