

PRIVATE AND CONFIDENTIAL

**SMOKING CESSATION SERVICE ASSESSMENT QUESTIONNAIRE**

This questionnaire will provide valuable information regarding your smoking habit. It will be used to follow your progress. We will not disclose it to anyone but it will be used anonymously for monitoring.

**PERSONAL DETAILS**

Name ..... Date of Birth..... Male  Female

Address.....

..... Post Code .....

Daytime phone number ..... Pregnant?: Yes  No

Occupation..... Registered GP Practice.....

How did you hear about the service?.....

**ABOUT YOUR SMOKING**

Age started smoking:.....How many do you smoke in a day now?.....

What do you smoke? cigarettes  cigars  hand rolled  Other.....

How soon do you smoke your first cigarette after waking up?:

30 min or less  30 min - 1 hour  More than one hour

**SMOKING MOTIVES**

Why did you start smoking?.....

Do you enjoy smoking? Yes  No  If yes, why?.....

Other reasons for smoking.....

In the past 12 months have you tried to quit and stayed off cigarettes for at least 24 hours? Yes  No  If yes, how many times.....

How long did you stop for each time? .....

If you have tried to stop in the past what worked?: .....

What didn't work? .....

**MOTIVATION TO STOP SMOKING**

Are you now seriously thinking about quitting smoking? Yes / No  
Yes, in the next 2 weeks  Yes, in next 6 weeks  Yes, in next year

Why do you want to give up smoking?  
.....  
.....

How confident are you that you will give up for good, on a scale of 1 to 10 (1 = not confident, 10 = very confident) .....

What concerns do you have about stopping smoking.....  
.....

**ABOUT YOUR HEALTH**

During the past 12 months have you had any of the following smoking related conditions?

- Trouble breathing or shortness of breath    Yes     No
- Frequent coughing    Yes     No
- Getting tired in a short time    Yes     No
- Pain or tightness in the chest    Yes     No
- Leg pain when walking    Yes     No

Any other health issues (please give details) .....

Have you ever suffered from depression or any other mental health illness? .....

Please list any medications you are taking (whether prescribed or not)  
.....  
.....

Please give details of any allergies you have.....  
.....

Please sign to confirm that the information on this form is correct:

Signature: ..... Date:.....

**PLEASE COMPLETE AND SIGN NEXT PAGE**