

Smoking Assessment Questionnaire

This questionnaire will provide valuable information regarding your smoking habit. Please answer the questions as best as you can and return it to us with the self-referral card provided. If you have any problems with the questions we will go through them with you then.

Personal Details

First Name: _____

Last Name: _____

Address: _____

Telephone: _____

Date of Birth: _____

Sex: _____

Expected Due Date
(If Pregnant) _____

About Your Smoking

- How do you feel about smoking? (please tick one)
 - I have no desire to stop
 - I would like to stop someday
 - I am going to stop within a month or less
 - I've stopped in the last six months
 - I stopped over 6 months ago
- In the past 12 months have you tried to quit and stay off cigarettes for at least 24 hours?
 - Yes, _____ times. (please state the number of times)
 - No
- Are you seriously thinking about quitting smoking?
 - No
 - Yes, within the next year
 - Yes, within the next 6 weeks
- If you have answered YES to question 3, which statement below best describes your attitude?
 - I have got to stop smoking
 - I must stop smoking
 - I want to be an ex-smoker
- During the last 12 months, have you experienced any of the following? (please tick)
 - Trouble breathing or shortness of breath
 - Frequent coughing
 - Getting tired in a short time
 - Pain or tightness in the chest
 - Leg pain when walking
- How do you feel about pressure from family, friends or work colleagues to give up smoking?
 - Resentful
 - Frustrated
 - I find it helpful

7 What will be the benefits to you of stopping?

8 What would help you stop smoking?

9 How many times have you tried to stop in the past? _____

What worked? _____

What didn't? _____

10 How much of a problem do you think these might be for you when you quit smoking?

	None	Some	A lot
Fear of failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being irritable, nervous, tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missing or craving cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losing a pleasure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being around other smokers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 How soon after you wake up do you usually smoke your first cigarette?

- Under 5 minutes
- 5 – 15 minutes
- 15 – 30 minutes
- 30 – 60 minutes
- 1 – 2 hours
- Longer than 2 hours

12 How many cigarettes do you smoke on a typical day?

- 10 or less
- 11 – 20
- 21 – 30
- 31 or more

- 13 Do you have anyone who will support you to stop smoking?
- No support available
 - Spouse / Partner
 - Family member
 - Friend
 - Work colleagues
 - Other
- 14 Are you currently living with a spouse or partner?
- Yes
 - No
 - No, I do not have a spouse or partner
- 15 Does anyone that you live with at home smoke regularly?
- Yes
 - No
 - Does not apply to me
- 16 What age were you when you started smoking?
- 17 How easy or difficult would you find it to go without smoking for a whole day?
- Very easy
 - Fairly easy
 - Fairly difficult
 - Very difficult
- 18 Do you smoke mainly for pleasure or because it helps you cope?
- About equally
 - Mainly for pleasure
 - Mainly to cope
- 19 Over the past 12 months, would you say your health has, on the whole been:
- Good
 - Fairly good
 - Not good
- 20 How determined are you to give up smoking at this attempt?
- Not at all determined
 - Quite determined
 - Very determined
 - Extremely determined

About Previous Use of Nicotine Replacement Therapy or Zyban

21 Have you ever tried nicotine chewing gum?

- Yes
 No (please go to question 22)

If YES, how long ago was your last piece?
_____ days / months (delete as appropriate)

How many pieces did you chew?

- 1 – 2
 3 – 10
 11 – 50
 More than 50

How helpful did you find it?

- Not at all helpful
 Quite helpful
 Very helpful

22 Have you ever tried nicotine skin patches?

- Yes
 No (please go to question 22)

If YES, how long ago did you use a patch?
_____ days / months (delete as appropriate)

How many patches did you use?

- 1 – 2
 3 – 10
 11 – 50
 More than 50

How helpful did you find it?

- Not at all helpful
 Quite helpful
 Very helpful

23 Have you ever tried any other forms of Nicotine Replacement Therapy? (please tick)

- Inhalator
 Microtab / Lozenge
 Nasal Spray
-
-

24 Have you ever tried using the drug Zyban (bupropion).

Yes

No

Did you complete the course?

Yes

No

If not, why did you stop taking it?

How helpful did you find it?

Not at all helpful

Quite helpful

Very helpful

Please give details of how helpful you found it / them?
