STOP SMOKING SERVICE ~CLIENT QUESTIONNAIRE

West Sussex NHS
Primary Care Trust

This questionnaire is designed to help you think about your smoking. It is helpful if parts 1–5 are filled in prior to meeting with the Smoking Adviser. If you have problems completing the form, the advisor will help.

IMPORTANT NOTICE

The information collected in this questionnaire is strictly confidential and is held securely in line with the Data Protection Act (1998). The information in itallics is required by the Department of Health and your Primary Care Trust for monitoring and evaluating our service – your advisor and the Primary Care Trust hold this information. The other information is held and used solely by clinical staff to guide your treatment and is not held by the West Sussex PCT. Any publication of data from the service will not identify individuals, and information will only be used where it is strictly necessary to do so. Please discuss any concerns you may have with the advisor. Your Smoking Cessation Advisor may contact you 1 year after your quit date to follow up your progress, if you do not wish them to do this please tick the box. ☐ (All maternal smokers will be followed up after one year) . If you are successful in your quit attempt your GP practice will be notified so that your status as a former smoker can be recorded onto practice systems. If you do not wish us to tell your GP that you have stopped smoking please tick the box ☐
You have the option not to share this information – if you wish to do so, please speak to your advisor.
Signing below indicates that you have read this notice and agree to its terms.

Signed... Date / /

1. PERSONAL DETAILS

Name ....

Address ....

.... Telephone No...

G.P. .... ***Full Postcode**** ....

DoB / / ***Age**** ....

Gender* *Male* ☐ *Female* ☐

Occupation* *: I would describe my current / last job role as (under 18's, show job role of parents)*

Please tick

Full-time student ☐ Never worked/long term unemployed ☐ Retired ☐
Home carer ☐ Sick/disabled ☐ Managerial/professional ☐
Intermediate ☐ Routine & manual ☐ Unable to code ☐

Ethnic group* *(please circle appropriate option)*

White	***Asian or Asian British***	***Black or Black British***	***Mixed***	***Other***
British	*Indian*	*Caribbean*	*White and Black Caribbean*	*Chinese*
Irish	*Pakistani*	*African*	*White and Black African*	*Other*
Other	*Bangladeshi*	*Other*	*White and Asian*	
	Other		*Other*	

Are you entitled to free prescriptions?* *. Yes* ☐ *No* ☐

2. ABOUT YOUR HEALTH

Are you pregnant?* ☐ *Yes* ☐

How would you describe your health over the past year? ☐ Good ☐ Fairly good ☐ Not good

Do you have any medical conditions caused or aggravated by smoking? ☐ Yes ☐ No

Have you been advised by your doctor to stop smoking? ☐ Yes ☐ No

Have you ever suffered from any of the following medical problems? Please circle all that apply.
Heart disease **/** Cancer **/** Stroke **/** Bronchitis/ Emphysema **/** Asthma **/** Stomach or duodenal ulcer **/** Epilepsy, seizures or fits **/** Head injury **/** Brain tumour **/** Eating disorder **/** Liver disease **/** Depression **/** Kidney disease **/** Diabetes

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify what and how much you would drink in a week.

……..

Do you take any medication? ☐ Yes ☐ No

If **YES**, please list **ALL** medication in the space below.

3. TOBACCO USE

How many years you have smoked? ....

Form of tobacco use *(please tick one or more)***:**

☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless or chewing tobacco

No of cigarettes per day ……… How much (hand rolling) tobacco do you use a week ……. ozs

How soon after waking do you have your first cigarette? …………hours…………minutes

Do you live with a smoker? ☐ Yes ☐ No

When do you smoke most? ☐ Morning ☐ Afternoon ☐ Evening

What is your favourite cigarette of the day?

☐ The first of the day ☐ After a meal .... ☐ Before bed Other: ……………………………..

4. PREVIOUS QUIT ATTEMPTS

Have you tried to stop smoking before? Yes ☐ No ☐

How many times? ………………………………….. **For how long?** ....

What aids have you used in the past?

☐ Gum / lozenge ☐ Patch ☐ Inhalator ☐ Nasal spray ☐ Microtabs

☐ Acupuncture ☐ Hypnosis ☐ Other……………………………………………………………..

What was the reason for your relapse? ……………………………………………………………

When you try to stop smoking, what side effects do you experience?

☐ Irritability ☐ Anxiety ☐ Sadness ☐ Headaches ☐ Insomnia ☐ Depression

☐ Loss of energy ☐ Increased appetite ☐ Loss of motivation ☐ Feelings of deviance

Other, please specify ……………………………………………………………………………………...

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5. STOPPING SMOKING

How would you rate your level of interest in stopping smoking? ☐ High ☐ Medium ☐ Low

How would you rate your level of confidence in succeeding? ☐ High ☐ Medium ☐ Low

Do you have any perceived problem areas in stopping smoking? *(Please tick all that apply)*

☐ Socialising ☐ Alcohol/pub ☐ Coffee break ☐ Stress relief ☐ Occupy hands

☐ Negative feelings ☐ Oral gratification Other……………….. ....

Why do you want to stop smoking?

....

What do you feel is the single biggest obstacle to your stopping smoking?

....

Are others pressuring you to stop smoking? ☐ Yes ☐ No

Please describe ....

Do you hide your smoking from others? ☐ Yes ☐ No

If yes, please say from whom and why...

As a smoker, which of the following do you experience?

☐ The frequent thought "I've got to quit?" ☐ Feelings of shame

☐ Feelings of guilt ☐ Hopelessness about stopping

☐ A sense of dread at the prospect of stopping ☐ Enjoyment of smoking

Other, please specify ……………………………………………………………………………………..

Is there anything else you would like to say?

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