SMOKERS QUESTIONNAIRE

SMOKING ASSESSMENT

This questionnaire will provide valuable information regarding your smoking habit (cigars, cigarettes, pipe)

Name _____ Date _____

Address _____

_____

1. **How do you feel about smoking**
   - Contented (not intending to stop) ☐
   - Concerned (thinking about stopping) ☐
   - Planning to stop (preparing) ☐

2. **In the past 12 months have you tried to quit and stayed off smoking for al least 24 hours?**
   Yes ☐ Number of times_____ No ☐

3. **Are you seriously thinking about quitting smoking?**
   No ☐ Yes in the next year ☐ Yes in the next six weeks ☐

Continue is answer to 3 is <u>Yes</u>

4. **If you have answered yes to the above question, which statement below best describes your attitude?**
   - I have got to stop smoking ☐
   - I must stop smoking ☐
   - I want to be an ex-smoker ☐

5. **During the past 12 months have you had any of the following conditions?**
   a. Trouble breathing or shortness of breath Yes ☐ No ☐
   b. Frequent coughing Yes ☐ No ☐
   c. Getting tired in a short time Yes ☐ No ☐
   d. Pain or tightness in the chest Yes ☐ No ☐
   e. Leg pain when walking Yes ☐ No ☐

6. **How do you feel about pressure from family, friends or work colleagues to give up smoking?**

   Resentful ☐ Frustrated ☐ Find it helpful ☐

7. **What do you like about smoking?**

8. **What will be the benefits of stopping?**

9. **What are your concerns about stopping?**

10. **What would help you in stopping?**

11. **How many times have you tried to stop in the past?**

    What worked?

    What didn't work?

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

a. Fear of failure	None ☐	Some ☐	Alot ☐
b. Being irritable, nervous or tense	None ☐	Some ☐	Alot ☐
c. Difficulty concentrating	None ☐	Some ☐	Alot ☐
d. Missing or craving cigarettes	None ☐	Some ☐	Alot ☐
e. Losing the pleasure	None ☐	Some ☐	Alot ☐
f. Gaining weight	None ☐	Some ☐	Alot ☐
g. Being around another smoker	None ☐	Some ☐	Alot ☐

13. **How soon do you smoke after waking up?**

    30 minutes or less ☐ 30 minutes to 1 hour ☐ More than 1 hour ☐

14. **How many cigarettes, cigars or ounces of tobacco do you smoke on a typical day?**

15. **How much help and understanding would you expect to find from family/friends if you tried to quit smoking?**

    None ☐ Some ☐ Alot ☐

Please return your completed questionnaire to:

Smoking Cessation Advisor
College Yard Surgery
Mount Street
Westgate
Gloucester GL1 2RE