NHS
South Gloucestershire

SMOKERS QUESTIONNAIRE

Please complete this form before your first appointment with the Stop Smoking Advisor

Name _____ Date of Birth_____

Please put circle number to indicate:

How important giving up smoking is to you

0 1 2 3 4 5 6 7 8 9 10

not important somewhat important very important

How confident are you in stopping at this attempt

0 1 2 3 4 5 6 7 8 9 10

not confident somewhat confident very confident

Why do you want to quit now?_____

_____

Please tick relevant box:

Have you ever tried to stop smoking before? Yes □ No □

Have you used other methods to stop smoking?

Cold Turkey □ Nicotine Replacement □ Hypnosis □

Acupuncture □ Joining a group □ Other □

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

		None	Some	A Lot
a	Fear of failure			
b	Being irritable, nervous or tense			
c	Difficulty concentrating			
d	Missing or craving cigarettes			
e	Losing a pleasure			
f	Gaining weight			
g	Being around other smokers			
h	Any other concerns (please state)			

How soon do you smoke after waking up?

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

How many cigarettes /tobacco do you smoke on a typical day? _____

How much help and understanding would you expect from family/friends when you stop?

None □ Some □ A lot □