

# Smoking Cessation Questionnaire

or place sticker here
Name: _____
ID#: _____
Date: _____

**Name:** \_\_\_\_\_

**ID#:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Major:** \_\_\_\_\_ **GPA:** \_\_\_\_\_ **Job:** \_\_\_\_\_

**Year in School:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** [  ] Female [  ] Male

1. Which of the following do you use: (check all that apply)  
 Cigarettes  Cigars  Pipe  Chew  Snuff  Other
2. How old were you when you first used tobacco? (check one box)  
 0-12  13-14  15-18  19-22  23-30  31-40  41-50  50+
3. How many packs per day do you currently smoke? (check one box)  
 0-1/2  1/2-1  1-1 1/2  2-3  3+  Less than 10 cigarettes a week
4. How much chewing tobacco do you use per day at present? (check one box)  
 1/4 of a tin  1/2 of a tin  1 tin  1 or more tins  N/A
5. How many people are living with you that use tobacco?  
 0  1  2  3 or more
6. Does your spouse/significant other use tobacco?  
 Yes  No  Not Applicable
7. Why do you want to quit? (check all that apply)  
 Health  Money  Family  Time  Smells Bad  To Be Smoke-Free  
 Social Acceptability  Other: \_\_\_\_\_
8. What is the longest time that you have gone without using tobacco? (check one box)  
 0-1 week  2-3 weeks  1-6 months  7-11 months  1-3 years  
 4-6 years  6+ years
9. When did this occur? (month, year, etc.) From \_\_\_\_\_ To \_\_\_\_\_
10. How many times have you tried to quit in the past? \_\_\_\_\_
11. What worked for you in the past? What helped you with your success?  
(check all that apply)  
 Exercise  Self Motivation  Change in Habits  Patch  Gum  
 Nothing  Don't Know  Hypnosis  Acupuncture  Individual Counseling  
 Group Counseling  Medicine  Not Applicable  Other: \_\_\_\_\_
12. What are you willing to change to become tobacco-free? (check all that apply)  
 Anything  Personal Habits  Lifestyle  Diet  Exercise routine  
 Other: \_\_\_\_\_
13. Who do you think will be supportive of your becoming tobacco-free?  
(check all that apply)  
 Family  Spouse  Friends  Everybody  Other: \_\_\_\_\_

place sticker here
Name: _____
ID#: _____
Date: _____

14. What do you think will help you not start again? (check all that apply)
- Determination/Will Power    Desire to be Smoke-Free    Support
- Changing Attitude    Other Stress Relievers
- If Spouse/Family/Friend also quit    Other: \_\_\_\_\_

15. How will you know you are successful / What are your goals?

\_\_\_\_\_

16. What fears do you have about your efforts to quit? (check all that apply)
- Mood Changes    Weight Gain    Loss of Control    Poor Self-Esteem
- Failure    Becoming Tense/Nervous    Other: \_\_\_\_\_

17. What are your major stressors? (check all that apply)
- Work    Family    Money    School    Own Health    Time
- Relationship    Family's Health    None    Other: \_\_\_\_\_

18. What have you done to help deal with stress in the past that helped? (check all that apply)
- Hobbies    Sleep    Drink    Eat    Relaxation    Listen to Music
- Read    Hypnosis    Exercise    Keep Busy/Active    Prayer    Nothing
- Other: \_\_\_\_\_

19. List any medications, herbs, vitamins that you currently take including over-the-counter products and medications that you take on as "as needed" basis.

<u>Medication</u>	<u>Dosage</u>	<u>How often you take it</u>	<u>Who prescribes it</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

20. List any health problems or current illnesses:

\_\_\_\_\_

\_\_\_\_\_

21. On a scale of 1-10, how would you rate your motivation today to stop using nicotine (1 = very low motivation, and 10 = very high)

Motivation \_\_\_\_\_

22. Have you ever been told you had a problem with addiction to alcohol or other drugs?

Yes    No

23. What drug/s have you abused in the past? \_\_\_\_\_

\_\_\_\_\_ Student Signature / Date

\_\_\_\_\_ Provider Signature / Date