

SMOKING QUESTIONNAIRE

Please give as much information as possible, thank you.

How many years have you smoked for? _____

Average number of cigarettes smoked per day in that time? _____

How soon after rising in the morning do you have your first cigarette?

Have you tried to stop smoking before? If Yes:

How long ago? _____

What made you relapse? _____

How long did you stop for and what did you use to help you not smoke?

Have you thought what you would like to use this time to help you stop? If

Yes what: _____

If you are serious about giving up smoking and are willing to attend for a review every 2 weeks, please telephone to arrange an appointment one week after returning this form.

The programme will end if you start smoking again.

SIGNATURE _____ Date _____

PRINT NAME _____ D.O.B. _____

For reception staff

Please arrange a **First Smoking** appointment with:

Nurse: Suzie Graham

Nurse: Janet Strangward or Caroline Jones