Mr/Mrs/Miss/Ms First Name _____ Surname _____

Today's Date _____ Date of Birth _____ Age _____

Address _____

e-mail address

Home tel _____ Mobile _____ Work _____

No. of dependent children _____ Occupation _____ GP _____

Questions about your smoking

How recently has your GP advised you to stop smoking? In the last year / More than a year ago / Never

Did your GP suggest you contacted Quitline on this occasion? Yes / No

What is your main reason for wanting to stop now? To save money / Protect my health / To please others / It's anti-social / Other reason

How many cigarettes do you usually smoke each day?

What type of cigarette do you usually smoke? Ultra lights / lights / standard / roll ups / cigars

Do you regularly use cannabis or legal highs? No / Yes With tobacco / Yes but not with tobacco

How old were you when you first started smoking regularly ?

How soon after waking do you usually smoke? Within 5mins / 6-15mins / 16-30mins / after 1 hour

Does your partner or anyone you live with smoke? No / Live alone / Yes Partner / Yes someone else

How often do you wake up in the night and smoke? Never / Rarely / 1-2 times a week / Most nights

Do you find it difficult not to smoke in non-smoking areas? Yes / No

Do you smoke more in the first few hours of the day? Yes / No

Do you smoke if you are so ill you are in bed for most of the day? Yes / No

How many times have you tried to stop in the last 5 years? Never / Once / 2-3 times / 4-5 times / over 5 times

What is the longest time you've succeeded in stopping for? Hours / days / weeks / 1-3 months / over 3 months

Which of these have you tried to help you stop? Nicotine Replacement Therapy, please specify type _____

Zyban / Champix / Any other method eg hypnotherapy, please specify _____

Have you had any side effects from a) Zyban Yes / No b) Champix Yes / No c) NRT Yes / No

What was the main thing that led you back to smoking last time? Got too miserable / Craved too much /

Put on weight / Got bad tempered / Got too stressed / Thought I could stop again easily / Cannabis smoking / Getting drunk / Something else

On a scale of 1-10 (1 least determined/confident and 10 very determined/confident)

How determined are you to stop for good in the next few weeks? 1 2 3 4 5 6 7 8 9 10

How confident are you of succeeding? 1 2 3 4 5 6 7 8 9 10

How did you hear about Quitline? Doctor / nurse / friend or family / radio / newspaper / poster or leaflet / other

Have you been to Quitline before? Yes / No - If yes how long ago _____

Are you a permanent Guernsey resident? Yes / No

Questions about your health

How many times have you been to your GP about your health in the last year? Not at all / 1 or 2 times / 3 or 4 times / 5 -10 times / more than 10 times.

In a typical WEEK how many alcoholic units (small glass of wine / half beer / single spirit) do you usually drink? None / 1-10 / 11-20 / 21-30 / 31-40 / 41-50 / more than 50

If you are female, are you Pregnant / Trying to conceive / Breast feeding / None of these

Have you ever suffered from these illnesses?			**Are you still being treated ?**		
	(circle one)		(circle one)		Name of any medicines you are STILL taking
Heart disease or condition	Yes	No	Yes	No	
Cancer	Yes	No	Yes	No	
Bronchitis	Yes	No	Yes	No	
High Blood Pressure	Yes	No	Yes	No	
Emphysema or COPD	Yes	No	Yes	No	
Asthma	Yes	No	Yes	No	
Alcohol Problems	Yes	No	Yes	No	
Drug Problems	Yes	No	Yes	No	
Depression	Yes	No	Yes	No	
Any form of psychosis	Yes	No	Yes	No	
Skin allergies or eczema	Yes	No	Yes	No	
Nasal problems or nose bleeds	Yes	No	Yes	No	
Bi-polar (high-low) depression	Yes	No	Yes	No	
A stroke	Yes	No	Yes	No	
An eating disorder	Yes	No	Yes	No	
Liver or kidney disease	Yes	No	Yes	No	
A brain tumour	Yes	No	Yes	No	
A head injury	Yes	No	Yes	No	
Fits or seizures or epilepsy	Yes	No	Yes	No	
Diabetes	Yes	No	Yes	No	

Any other current illness not listed above?

Any other medicines / tablets / injections not listed above?

Are you due for surgery? Yes / No If yes please give details

Have you had recent surgery? Yes / No If yes please give details

All information collected is confidential and will be stored in accordance with Data Protection. I am aware I will be contacted by Quitline following my quit attempt to record progress.
I understand and agree that the data may be passed on to my Doctor.

Signed _____ **Date** _____

To be completed by Stop Smoking Specialist

Cessation method

Quit date _____ Coppm _____

Client seen : Group Drop In 1 to 1 Home visit Hospital inpatient

Any further information

NRT products given …….. Received by …….

Staff signature …….