

# Smoking Assessment Questionnaire

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

Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

---

## Smoking History

1. At what age did you begin to smoke? \_\_\_\_\_
2. How many cigarettes do you smoke before starting the work day? \_\_\_\_\_
3. How many cigarettes do you smoke during the work day? \_\_\_\_\_
4. How many cigarettes do you smoke after the work day? \_\_\_\_\_
5. What is the total number of cigarettes smoked per day? \_\_\_\_\_
6. What is the total number of cigarettes smoked per day during the weekend? \_\_\_\_\_
7. How many cigarettes have you smoked per day during your heaviest smoking period? \_\_\_\_\_
8. How many times have you tried to stop smoking? *(Please check one.)*

- \_\_\_\_ Never
- \_\_\_\_ One
- \_\_\_\_ Two
- \_\_\_\_ Three
- \_\_\_\_ Four
- \_\_\_\_ Five
- \_\_\_\_ Six or more

9. What is the longest period of time you have gone without smoking since you first started smoking regularly? *(Please check one.)*

- \_\_\_\_ 1 week or less
- \_\_\_\_ 1 week - 1 month
- \_\_\_\_ >1 month - 6 months
- \_\_\_\_ >6 months - 1 year
- \_\_\_\_ longer than 1 year

10. Have you ever tried to stop smoking before using the following methods? *(Check all that apply.)*

- Clinic or group
- Written materials
- Cold Turkey
- Gradual reduction
- Special filters
- Stop with a friend (buddy system)
- Hypnosis
- Self-help program
- Medications
- List: \_\_\_\_\_

### **Current Plan to Stop Smoking**

1. How interested are you in stopping smoking? *(Please check one.)*

- strongly
- very
- somewhat
- a little
- not at all

2. If you decide to quit smoking completely, during the next two weeks, how confident are you that you will succeed? *(Please check one.)*

- strongly
- very
- somewhat
- a little
- not at all

3. Do the following people smoke?

- Family (those living with you)
- Friends
- Coworkers

4. Are family members ( encouraging / discouraging ) you from trying to stop smoking?  
*(Please circle one.)*