Pre-Quitting Questions

Name ______________________ Age ____ Sex ____ Date __________

Home Address ________________ Work Address __________________

____________________________ ______________________________

____________________________ ______________________________

Home phone __________________ Work Phone ___________________

When and where is the best time to phone you? ______________________

Email address __________________________

Please provide contact information for someone who would always know how to reach you (name, phone number, email address).

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1. Exactly what cigarette brand do you smoke? ______________________
2. In an average day, how many cigarettes do you usually smoke? ________
3. After you wake up, about how many <u>minutes</u> usually pass before you smoke your first cigarette? __________
4. In past stop-smoking attempts, what medications have you tried (patches, gum, Zyban®)? ______________________
5. How many cups/glasses do you have each day of drinks with caffeine (coffee, tea, cola, Mt. Dew®, Dr. Pepper®)? __________
6. How many drinks with alcohol do you have each day? __________
7. Do you use other forms of tobacco (pipes, cigars, snuff, chewing tobacco) once a week or more? ❑ Yes ❑ No
8. Do you have physical signs of excess tension (headaches, difficulty sleeping, upset stomach)? ❑ Yes ❑ No
9. Over the last 2 weeks, have you often felt downhearted, depressed, and hopeless? ❑ Yes ❑ No

Please turn this page for more questions.

10. In the *past*, have you ever felt very depressed and hopeless every day for 2 weeks or longer? ☐ Yes ☐ No

11. Do you take anti-depressant medication? ☐ Yes ☐ No

12. Do you have high blood pressure? ☐ Yes ☐ No

13. Have you had a heart attack in the past 6 months? ☐ Yes ☐ No

14. Do you have a serious skin condition or allergy? ☐ Yes ☐ No

15. Have you ever had a seizure? ☐ Yes ☐ No

16. If female, are you pregnant or breast-feeding? ☐ Yes ☐ No

17. Have you ever had an eating disorder? (bulimia or anorexia nervosa) ☐ Yes ☐ No

18. We may want to write your doctor. If we have your permission to do so, please provide:

    Doctor's Name: ______________________________

    Address: ______________________________

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Check with your doctor before using any stop-smoking medication(s).

Please provide any additional information you believe we should know to help you break free from cigarettes.

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Congratulations on your decision to break free from cigarettes!

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