Quit4life HAMPSHIRE STOP SMOKING SERVICE

Client Questionnaire

GP Surgeries and Pharmacy only

Southern Health NHS
NHS Foundation Trust

CONFIDENTIAL: All information will be kept securely and in accordance with the Caldicott Guidelines and the Data Protection Act 1998.

Client Signature

Agreeing to Quit4life support indicates consent to treatment and the sharing of outcome data with your GP and/or referrer.

Data may also be used for follow up and service review purposes including by an approved third party where applicable.

Signed: ………………………………………………………………………………… Date: ……………………………………………………………

About You

QM Client Number (office use only):

Full Name		Gender	
Address		Date of Birth	/ /
		GP Name	
		GP Surgery	
Postcode			

Contact Details (It is important that we are able to stay in touch with you)

Mobile Number		
Other Phone Number		
Email:		

Other Information

How did you hear about Quit4life?		Do you pay for prescriptions?	☐ Yes ☐ No
Have you been referred to us?	☐ Yes ☐ No	If yes, who has referred you?	
Do you work for Southern Health Foundation Trust?	☐ Yes ☐ No	Have you been referred for surgery by your GP?	☐ Yes ☐ No
Have you been in hospital within the last 4 weeks?	☐ Yes ☐ No	Are you currently using any type of E-cigarette or vaping? If you are, please discuss with your Adviser	☐ Yes ☐ No

About Your Smoking

Q1. How many do you smoke a day: ____________ What do you smoke:

Q2. Do you use tobacco in any other form? ☐ Yes ☐ No If yes, what?

Q3. How soon after waking do you smoke?	Within 5 minutes ☐	6-30 minutes ☐	31-60 minutes ☐	Over 60 minutes ☐

Q4. Do you find it difficult NOT BEING ABLE TO SMOKE in places where smoking is NOT ALLOWED?	Yes I find it difficult if I can't smoke ☐
	No I don't find it difficult ☐
Q5. Which cigarette is the hardest to quit? (please tick one only)	First in the morning ☐
	Any of the others ☐

Q6. Do you smoke more during the first hours after waking than during the rest of the day? ☐ Yes ☐ No	Q7. Do you smoke even if you are ill in bed all day? ☐ Yes ☐ No	Q8. How many years since you started smoking? ____________ years
Q9. Do you have children living with you (under 18's)? ☐ Yes ☐ No	Q10. Do you live with other smokers? ☐ Yes ☐ No	Q11. Do you use home oxygen? ☐ Yes ☐ No

PLEASE CONTINUE TO THE NEXT PAGE

Office Use Only				
Planned Quit Date				Actual Quit Date
Date	CO	Quit Y/N	Products	Comments

Your Health

Are you: Planning a pregnancy? ☐ Yes ☐ No (if yes, is it currently ☐ Yes within 3 months ☐ Yes within year ☐ Yes)

Are you: Pregnant? ☐ Yes ☐ No

Are you: Currently breastfeeding? ☐ Yes ☐ No

Please tick current and previous health concerns: -

☐ Alcohol Abuse	☐ Circulatory	☐ Emphysema	☐ Hypertension	☐ Registered Disabled
☐ Angina	☐ Cirrhosis	☐ End Stage Renal Failure	☐ Kidney Disease	☐ Skin Conditions
☐ Asthma	☐ Collapsed Lung	☐ Epilepsy	☐ Liver Disease	☐ Stomach Ulcer
☐ Bi-Polar	☐ Contact with TB	☐ Gastric Ulcer	☐ Mental Illness	☐ Stroke
☐ Blood Pressure	☐ COPD	☐ Head Injury	☐ Oesophagitis	☐ Thyroid disease
☐ Bronchitis	☐ Depression	☐ Heart attack	☐ Other Stomach Problems	☐ Thyroid: Overactive
☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ Peptic Ulcers	☐ Vascular
☐ Coronary Heart Disease (CHD)	☐ Eating Disorder	☐ Hepatitis C	☐ Psoriasis	☐ Other (give details)
☐ Chest Problems	☐ Eczema	☐ HIV/Aids	☐ Reaction to NRT	

☐ I confirm I do not have any relevant medical conditions and am not taking any relevant medication

When giving up smoking certain medications can be affected and your current dosage may need to be adjusted. Please discuss with your Adviser and GP if you are unsure.

Your Medicine – Please tick any medicines you are taking or give details

Antidepressants:

☐ SSRIs e.g. Fluoxetine, Citalopram, Paroxetine, Sertraline	☐ SNRIs e.g. Duloxetine, Venlafazine	☐ TCAs e.g. Amitriptyline, Clomipramine, Imipramine, Lofepramine, Nortriptyline	☐ MAOIs e.g. Moclobemide, Phenelzine

Other Medications:

☐ Anticonvulsants e.g. Carbamazepine, phenytoin, phenobarbital, primidone	☐ Benzodiazepines, e.g. diazepam, lorazepam, chlordiazepam, chlordiazepoxide, oxazepam, temazepam, nitrazepam, loprazolam, lormetzaepam, clobazam, clonazepam.	☐ Beta-blockers, e.g. acebutolol, atenolol, bisoprolol, carvedilol metoprolol, nadolol, nebivolol, propranolol
☐ Clozapine, clozaril, Denzapine, Zaponex	☐ Cimetidine Ranitidine	☐ Duloxetine e.g. Cymbalta, Yentreve
☐ Flecainide, Tambocor	☐ Fluvoxamine e.g. Fluvoxamine, Faverin	☐ Haloperidol, Dozic, Haldol, Serenace
☐ Insulin	☐ Memantine, Ebixa	☐ Mirtazapine, Zispin, SolTab
☐ Olanzapine	☐ Pentazocine	☐ Phenothiazines e.g. Chlorpromazine
☐ Propanolol	☐ Theophylline e.g. Nuelin SA, Slo-Phyllin, Uniphyllin Continus.	☐ Verapamil, Cordilox, Securon
☐ Warfarin	☐ Zolpiderm, zaleplon, zopiclone	☐ List any other Medications here:

What is your Ethnic Group?	White			Mixed			Asian or Asian British	
		British			White and Black Caribbean			Indian
		Irish			White and Black African			Pakistani
		Other White Background			White and Asian			Bangladeshi
					Other Mixed Background			Other Asian Background
	Black or Black British						Other	
		African		Other Ethnic Groups				Polish
		Caribbean			Chinese			Nepali
		Other Black Background			Other Ethnic Group			Gypsy or Traveller
								Not Stated

What is your occupation?

Sexual Orientation				
Heterosexual/ Straight ☐	Gay or Lesbian ☐	Bisexual ☐	Other ☐	Do not wish to disclose ☐