SCIMITAR

Smoking Cessation in Mental Ill health Trial

Biographical Questionnaire

For office use only

Trial ID ☐☐☐☐

Date ☐☐/☐☐/☐☐☐☐

Funded by:
NIHR HTA code 07/41/05
ISRCTN 79497236
Biographical Questionnaire v2.0

Organised by:

The University of York

Manchester 1824

Section A – General Health

1. What is your date of birth? ☐☐ / ☐☐ / ☐☐☐☐
   (please write your date of birth) *day* *month* *year*
2. Are you — Male ☐ Female ☐
3. How would you describe your health over the past year? *(circle one number)*

Excellent	1
Good	2
Moderate	3
Poor	4
Very poor	5

4. How many times have you consulted your GP in the last 12 months? _____times
5. Do you feel that smoking has affected the state of your health? Yes ☐ No ☐
6. Has your GP or any other doctor advised you to quit smoking? Yes ☐ No ☐
7. Are you pregnant or breastfeeding? Yes ☐ No ☐
8. Have you ever suffered from any of the following health problems?

Heart disease	Yes ☐ No ☐
Cancer	Yes ☐ No ☐
Stroke	Yes ☐ No ☐
Bronchitis/emphysema	Yes ☐ No ☐
Asthma	Yes ☐ No ☐
Stomach or duodenal ulcer	Yes ☐ No ☐
Epilepsy, seizures or fits	Yes ☐ No ☐
Head injury	Yes ☐ No ☐
Brain tumour	Yes ☐ No ☐
Eating disorder	Yes ☐ No ☐
Liver disease	Yes ☐ No ☐
Kidney disease	Yes ☐ No ☐

9. Do you drink alcohol? Yes ☐ No ☐
   If yes, please specify what you drink: *how much you drink*
   _____ _____*per week*
10. Do you take recreational drugs? Yes ☐ No ☐
    If yes, please specify what you take: *how much you take*
    _____ _____*per week*

Any comments about General Health?

Section B – Sociodemographic Details

1. How would you describe your ethnic background?*(please cross one box)*

White – British	☐ 1
White – Irish	☐ 2
Any other White background	☐ 3
Mixed – White and Black Caribbean	☐ 4
Mixed – White and Black African	☐ 5
Mixed – White and Asian	☐ 6
Any other mixed background	☐ 7
Asian or Asian British – Indian	☐ 8
Asian or Asian British – Pakistani	☐ 9
Asian or Asian British – Bangladeshi	☐ 10
Any other Asian background	☐ 11
Black or Black British - Caribbean	☐ 12
Black or Black British - African	☐ 13
Chinese	☐ 14
Other, please specify here _____	☐ 15

2. What is your highest educational qualification?

GCSE/ O level	☐ 1
GCE A/AS level or Scottish Higher	☐ 2
NVQ/SVQ levels 1-3	☐ 3
GNVQ (Advanced)	☐ 4
B Tec Certificate	☐ 5
B Tec Diploma	☐ 7
National Certificate or Diploma (ONC/ OND/ HNC/HND)	☐ 8
Qualified Teacher Status	☐ 9
Higher Education Diploma	☐ 10
Degree (First Degree/ Ordinary Degree)	☐ 11
Post Graduate Certificate	☐ 12
Post Graduate Diploma	☐ 13
Masters Degree	☐ 14
PhD	☐ 15
Other: please specify _____	☐ 16
Don't know/no response	☐ 17

5. How would you describe your employment status?
(please cross the box that describes you best)

- Employed full-time (30+ hours per week) ☐ 1
- Employed part-time (<30 hours per week) ☐ 2
- Self-employed ☐ 3
- Retired ☐ 4
- Looking after family or home ☐ 5
- Student (full or part-time) ☐ 6
- Voluntary worker (paid or unpaid) ☐ 7
- Not employed but seeking work ☐ 8
- Not employed but **not** seeking work because of ill health ☐ 9
- Not employed, but **not** seeking work for some other reason ☐ 10
- Other, please specify here _____ ☐ 11

5a. What is your job title: _____

5b. In the last six months, how many weeks have you been working ☐ 1

5c. On average, how many hours do you work per week ☐ 2

5d. What is your current weekly wage before tax? £ ☐ 3

5e. If unemployed, how long have you been unemployed?

- < 3 months ☐ 1
- 4-12 months ☐ 2
- 1-2 years ☐ 3
- 2-5 years ☐ 4
- >5 years ☐ 5
- Don't know/no response ☐ 6

6. What is your marital status?
(please cross one box)

- Single ☐ 1
- Married ☐ 2
- Living with a partner/co-habiting ☐ 3
- Divorced/separated ☐ 4
- Widowed ☐ 5
- Never married ☐ 6
- Other (please specify) ☐ 7
- Don't know/no response ☐ 8

7. Do you have any children

(please cross one box)

Yes	☐	1
No	☐	2

7a. If yes, how old are your children

1	Years	1
2	Years	2
3	Years	3

8. What is your current accommodation type

(please cross one box)

Detached house	☐	1
Semi-detached house	☐	2
Terraced house	☐	3
Flat	☐	4
Bedsit/studio	☐	5
Communal establishment	☐	6
Caravan/other mobile shelter	☐	7
No fixed abode	☐	8

8a. What type of accommodation have you lived in within the last six months

	Number of days	
Domestic accommodation (owned or rented)		1
Living with friends or relatives		2
Bed & breakfast, boarding house or hotel		3
Homeless, living on the streets		4
Staffed accommodation (staffed during the day only)*		5
Staffed accommodation (staffed day and night)*		6
Other please specify _____		7

*may include hostel, shelter, refuge, half-way house, NHS residential accommodation

9. Do you have other people living with you?

Yes	☐	1
No	☐	2
Don't know/no response	☐	3

9a. If yes to question 9, how many? _____ people

Section C - Mental health status

1. What is the term used to describe your mental health problem? _____

2. When were you diagnosed with your mental health problem _____

3. What is the name of your psychiatrist? _____

   Contact Details: _____

   Phone number: _____

4. Are you seen by:

   Care Programme Approach (CPA) coordinator? Yes ☐ No☐

   Community Psychiatric Nurse (CPN) ? Yes ☐ No☐

   Community Mental Health Team? Yes ☐ No☐

5. Name of key mental health care worker? _____

   Contact Details: _____

   Phone number: _____

6. What was the date of your most recent annual health check? _____/_____/_____

7. In the last 10 years, how many times have you needed psychiatric treatment in hospital? _____times

8. Would you describe your condition as:

   Stable ☐

   Unstable ☐

   Unsure ☐

9. Do you take any medications: Yes ☐ No☐

   *If yes, please list **ALL** medications below:*

Any comments about Mental Health?

Section D - Smoking History

1. How long have you been a smoker? _____years_____months

2. What type of tobacco do you use?

Packet cigarettes	☐
Hand-rolled cigarettes	☐
Cigars	☐
Pipe	☐
Chewing tobacco	☐
Water pipe/hookah/sheesha pipe	☐

3. How many cigarettes do you usually smoke per day? _____cigarettes/packets

4. If you use roll-ups or a pipe, how much tobacco do you usually use per day? _____ounces/grams

5. How many times have you tried to give up smoking in the past? _____attempts

6. What is the longest period of time that a quit attempt has lasted? _____days/weeks

7. Have you ever tried nicotine chewing gum? Yes ☐ No☐
   If yes, how many pieces did you use altogether? _____pieces

8. Have you ever tried nicotine skin patches? Yes ☐ No☐
   If yes, how many patches did you use altogether? _____patches

9. Have you ever tried nicotine nasal spray? Yes ☐ No☐
   If yes, how many bottles did you use altogether? _____bottles

10. Have you ever tried nicotine inhalator? Yes ☐ No☐
    If yes, how many cartridges did you use altogether? _____cartridges

11. Have you ever tried nicotine microtab? Yes ☐ No☐
    If yes, how many tablets did you use altogether? _____tablets

12. Have you ever tried nicotine lozenges? Yes ☐ No☐
    If yes, how many lozenges did you use altogether? _____lozenges

Any comments about past quit attempts?

13. Have you tried any other methods to stop smoking?

Zyban (Bupropion)	Yes ☐	No☐
Champix (Varenicline)	Yes ☐	No☐
Cold Turkey	Yes ☐	No☐
Hypnosis	Yes ☐	No☐
Acupuncture	Yes ☐	No☐
Other (Please state_____	Yes ☐	No☐

14	How important are these reasons for smoking?	Very important	Quite important	Not Important
	It helps me relax	☐	☐	☐
	It helps to break up my working time	☐	☐	☐
	It is something to do when I am bored	☐	☐	☐
	It helps me cope with stress	☐	☐	☐
	I enjoy it	☐	☐	☐
	It's something I do with my family & friends	☐	☐	☐
	It stops me putting on weight	☐	☐	☐
	It stops me getting withdrawal symptoms	☐	☐	☐

15	What are your reasons for trying to give up smoking?	Very important	Quite important	Not Important
	It is expensive	☐	☐	☐
	It is bad for my health	☐	☐	☐
	I don't like feeling dependent on cigarettes	☐	☐	☐
	It makes my clothes and breath smell	☐	☐	☐
	It is a bad example for children	☐	☐	☐
	It is unpleasant for people near me	☐	☐	☐
	It makes me less fit	☐	☐	☐
	People around me disapprove of my smoking	☐	☐	☐
	It is bad for the health of people near me	☐	☐	☐

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Questionnaire

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Organised by:

THE UNIVERSITY of York MANCHESTER 1824

PLEASE READ ALL THE INSTRCUTIONS BEFORE COMPLETING THE QUESTIONNAIRE

Thank you for taking part in this study and agreeing to compete this questionnaire.

The responses you give to this questionnaire will provide information to help health professional manage smoking cessation in people with mental health problems.

The information you provide will be kept strictly confidential. You will not be personally identified in any report resulting from this study.

Please answer ALL the questions. Although some of the questions may appear similar, repetitive or seem irrelevant, it is important to the study that you answer every one. Please answer all questions honestly and to be nest of your ability.

Follow the instructions for each question carefully.

When answering the questions, use a cross rather than a tick, as if you are filling out a ballot paper. For example in the following question, if your answer is yes, you should place the cross firmly in the box next to yes.

Example:

Do you smoke? Yes ☒

No ☐

If you are asked to write an answer, please print clearly.

Example:

What is your age? | 3 | 8 |

Where were you born? DISTRICT Hospital

Please use a black or blue pen. Please do not use a pencil or coloured pen.

If you have any queries or problems completing this questionnaire, please contact your local study centre:

<Local study centre trial coordinator>
Trial coordinator name
Address
Phone number
Email

Smoking Status
This section is about your smoking now and your attempt to quit smoking.

1. Have you smoked in the last week?
(*please put a cross in one box only*)

Not even a puff ☐
Yes just a few puffs ☐
Yes between 1 and 5 cigarettes ☐
Yes more than 5 cigarettes ☐

If 'yes', please answer questions 1a and 1b:

1a. What time of day did you have the first puff? ☐☐:☐☐ am/pm

(*Please write the time of day in the box and* ***circle a.m. or p.m.***)

1b. How many cigarettes are you normally smoking per day? ☐☐ Cigaretters /packets
(*Please* ***circle cigarettes or packets***)

*Baseline and 12 month follow-up only
Breath carbon monoxide reading = ☐ ppm
☐ COHb

2. Which of the following statements best describes you at the moment?

I smoke the same amount of cigarettes (including hand-rolled) every day ☐
I have cut down on the number of cigarettes (including hand-rolled) I smoke ☐
I smoke cigarettes (including hand-rolled) but not every day ☐
I have stopped smoking completely ☐

3. How many quit attempts to stop smoking ☐☐☐ attempts
Have you made in the last 6 months?

4. How long did your most recent quit attempt last before you went back to smoking?

Days ☐☐ Weeks ☐☐ Months ☐☐

Fagerstrom Test of Nicotine Dependence (FTND)
This set of questions will enable us to see how dependent you are on your cigarettes.

1. How soon after you wake up do you smoke your first cigarette?
(*Please cross one box only*)

- Within 5 minutes ☐
- 6-30 minutes ☐
- More than 30 minutes ☐

2. Do you find it difficult to stop smoking in no-smoking areas?
(*Please cross one box only*)

- Yes ☐
- No ☐

3. Which cigarettes would you most hate to give up?
(*Please cross one box only*)

- The first of the morning ☐
- Other ☐

4. How many cigarettes per day do you usually smoke?
(*Please write the number on the line and cross one box only*) ☐ per day

- 10 or less ☐
- 11 to 20 ☐
- 21 to 30 ☐
- 31 or more ☐

5. Do you smoke more frequently in the first hours after waking than during the rest of the day?
(*Please cross one box only*)

- Yes ☐
- No ☐

6. Do you smoke if you are so ill that you are in bed most of the day?
(*Please cross one box only*)

- Yes ☐
- No ☐

7. Do you smoke hand rolled cigarettes?
(*Please cross one box only*)

- Yes ☐
- No ☐

If 'yes', please answer questions 7a and 7b

7a. How many do you usually smoke per day? ☐ per day

7b. How much tobacco do you usually use per day? ☐ ounces

Motivation to Quit questionnaire
This next set of questions tells us about your motivation to stop smoking.

1. How important is it for you to give up Smoking altogether at this point in time? (*Please cross in one box only*)

- Desperately important ☐
- Very important ☐
- Quite important ☐
- Not all that important ☐

2. How determined are you to give up Smoking at this point in time? (*Please cross one box only*)

- Extremely determined ☐
- Very determined ☐
- Quite determined ☐
- Not all that determined ☐

3. Why do you want to give up smoking? (*Please cross the most important box*)

- Because my health is already suffering ☐
- Because I am worried about my future health ☐
- Because smoking costs too much ☐
- Because other people are pressurising me to ☐
- For my family's health ☐

4. How high would you rate your chances of giving up smoking for good at this point in time? (*Please cross one box only*)

- Extremely high ☐
- Very high ☐
- Quite high ☐
- Not very high ☐
- Low ☐
- Very low ☐

PHQ9
This section is about how you have been feeling in the last 2 weeks
Answer each question by placing a cross in the box that best describes your answer

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(*Please cross one box per row only*)

	Not at All	Several days	More than half the days	Nearly every day
1. Little interest or please in doing things	☐	☐	☐	☐
2. Feeling, down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
8. Trouble concentrating on things, such as reading the newspaper or watching TV	☐	☐	☐	☐
7. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

EQ5D

By placing a cross in one box in each group below, please indicate which statement best describes your own health state today.

Mobility

I have no problems waking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

Self-care

I have no problems with self-care ☐

I have some problems washing or dressing myself ☐

I am unable to wash or dress myself ☐

Usual activities (e.g. work, study, housework, family or leisure activities)

I have no problems with performing my usual activities ☐

I have some problems with performing my usual activities ☐

I am unable to perform my usual activities ☐

Pain/Discomfort

I have no pain or discomfort ☐

I have some pain or discomfort ☐

I have extreme pain or discomfort ☐

Anxiety/Depression

I am not anxious or depressed ☐

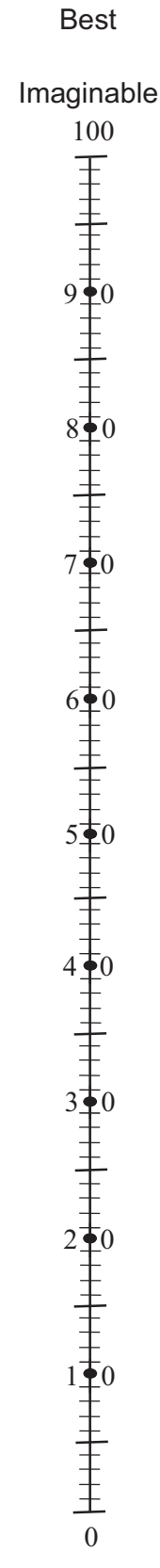
I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



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SF12

These questions ask for your views about your health. This section will help us to keep track of how you feel and how well you are able to do your usual activities.

Answer each question by marking a cross in the appropriate box. If you are unsure on how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
   (P*lease cross one box only*)

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. During a typical day does **your health** limit you in **moderate activities**, such as moving a table, pushing the vacuum cleaner, bowling or playing golf? If so, how much?
   (*Please cross one box only*)

Yes, limited a lot	Yes, limited a little	No, not at all limited
☐	☐	☐

3. During a typical day does your health limit you in climbing several flights of stairs? If so, how much?
   (*Please cross one box only*)

Yes, limited a lot	Yes, limited a little	No, not at all limited
☐	☐	☐

4. During the **past 4 weeks**, how much of the time have you accomplished less than you would like in regular daily activities **as a result of your physical health**?
   (*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

5. During the **past 4 weeks**, how much of the time have you been limited in performing any kind of work or other regular daily activities **as a result of your physical health**?
   (*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

6. During the **past 4 weeks**, how much of the time have you been limited in performing any kind of work or other regular daily activities **as a result of any emotional problems (**such as feeling depressed or anxious**)**?
   (*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

7. During the **past 4 weeks**, how much of the time have you done work or other activities less carefully than usual **as a result of any emotional problems** (such as feeling depressed or anxious)?
(*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

8. During the **past 4 weeks**, how much did **pain interfere with your normal work** (both outside the home and housework)?
(*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

9. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes the closest to the way you have been feeling. How much during the **past four weeks** have you felt calm and peaceful?
(*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

10. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes the closest to the way you have been feeling. How much during the **past four weeks** did you have a lot of energy?
(*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

11. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes the closest to the way you have been feeling. How much during the **past four weeks** did you feel downhearted and depressed?
(*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

12. During the **past 4 weeks** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives etc.)?
(*Please cross one box only*)

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Health Economics/ Service Utilisation Questionnaire
The next section is about any health care you have received as a patient for any reason.

1. Have you attended an accident and emergency department (A&E) in the **last six months**?

Yes ☐ No ☐ Don't know ☐

If 'Yes', please record details below:

Reason	Admitted Yes / No	Number of nights stayed
	☐ ☐	☐☐☐
	☐ ☐	☐☐☐
	☐ ☐	☐☐☐

2. In the **last six months**, have you had a planned hospital admission where you have stayed in hospital overnight?

Yes ☐ No ☐ Don't know ☐

If 'Yes', please record details below:

Reason	Number of nights
	☐☐☐
	☐☐☐
	☐☐☐

3. Have you been to hospital for an outpatient appointment in the **last six months**?

Yes ☐ No ☐ Don't know ☐

If 'Yes', please record details below:

Details of appointment	Number of appointments
	☐☐☐
	☐☐☐
	☐☐☐

4. Have you been in hospital as a day case/procedure patient in the **last six months**?

Yes ☐ No ☐ Don't know ☐

If 'Yes', please record details below:

Details of day case/procedure	Number of appointments
	☐☐☐
	☐☐☐
	☐☐☐

5. Have you used a '999' emergency ambulance in the **last six months**?

Yes ☐ No ☐ Don't know ☐

If 'Yes' how many times in the **last six months**? ☐☐☐

6. Have you used the Patient Transport Service in the **last six months**?

Yes ☐ No ☐ Don't know ☐

If 'Yes' how many times in the **last six months**? ☐☐☐

Community Services

7. Have you had any contact with any of the following community based professionals or services in the **last six months**:

Services	Number of Contacts
1. General practitioner – home	
2. General practitioner – surgery (including NHS walk-in clinic)	
3. General practitioner – telephone	
4. Practice nurse (nurse in GP surgery)	
5. District nurse, health visitor	
6. Care co-ordinator, case manager, key worker	
7. Psychiatrist	
8. Clinical psychologist	
9. Community psychiatric nurse	
10. CAMHS worker, STAR worker or advocate	
11. Counsellor (NHS, school/college or private)	
12. Family therapist	
13. Art/drama/music/occupational therapist	
14. Social worker	
15. Family support worker	
16. Social services youth worker	
17. Accommodation key worker	
18. Connexions	
19. Mentor	
20. Drug/alcohol support worker	
21. Advice service e.g. citizen's advice bureau, housing association	
22. NHS Direct telephone helpline	
23. Other helplines e.g. Samaritans, MIND, Mental Health	
24. Day centre/drop-in centre	
25. Complementary therapist e.g. homeopath, osteopath, reflexologist	
26. Any other health service e.g. Dentist – give details:	
27. Other – give details:	

Other smoking cessation services

8. In the **last six months**, how many times have you asked for help or advice from:

	Number of contacts
A pharmacist	☐☐☐
Your mental health smoking cessation practitioner	☐☐☐

9. In the **last six months**, have you used these other services:

Phoned the NHS stop smoking helpline service	☐☐☐
Phoned other smoking helplines e.g. QuitLine	☐☐☐
Used the internet to look for help and support on stopping smoking	☐☐☐
Used self-help books for advice to stop smoking	☐☐☐

10. In the **last six months**, have you used any nicotine replacement therapy (NRT) products to help you quit smoking:

*Yes ☐ No ☐ Don't know ☐

If '**Yes**', please complete the following:

Did you use Nicotine patches? *Yes ☐ No ☐ Don't know ☐

*If '**Yes**':

How many pieces of patches did you use? ☐☐☐ Patches

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

Did you use Nicotine gum? *Yes ☐ No ☐ Don't know ☐

*If '**Yes**':

How many pieces of gum did you use? ☐☐☐ Pieces

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

Did you use Nicotine lozenges? *Yes ☐ No ☐ Don't know ☐

*If '**Yes**':

How many lozenges did you use? ☐☐☐ Lozenges

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

Did you use Nicotine microtabs? *Yes ☐ No ☐ Don't know ☐

*If '**Yes**':

How many pieces tablets did you use? ☐☐☐ Tablets

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

Did you use Nicotine Inhaler? *Yes ☐ No ☐ Don't know ☐

*If '**Yes**':

How many cartridges did you use? ☐☐☐ Cartridges

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

Did you use Nicotine Nasal Spray? *Yes ☐ No ☐ Don't know ☐

*If '**Yes**':

How many bottles did you use? ☐☐☐ Bottles

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

Did you get them on a GP prescription? Yes No Don't know

Did you use any Other Nicotine Replacement Product?

e.g. mouth spay, e-cigarette *Yes ☐ No ☐ Don't know ☐

*If '**Yes**', please state the product used: ☐

How much did you use? ☐

How long did you use them for? Days ☐☐ Weeks ☐☐ Months ☐☐

Did you get them on a GP prescription? Yes ☐ No ☐ Don't know ☐

11. In the **last six months**, have you used **Zyban (Bupropion)** to help you quit smoking?

*Yes ☐ No ☐ Don't know ☐

If 'Yes', how many quit attempts did you try using Zyban (Bupropion)? ☐☐ attempts*

For each most recent attempt, please state how long you used Zyban for?

	Less than 24 hours	24 hours	1 to 6 days	7 to 14 days	2 to 4 weeks	Longer than 4 weeks	Cannot remember
Most recent Quit attempt	☐	☐	☐	☐	☐	☐	☐

*If more than 1 attempt was made using Zyban, please put details in the comment box.

12. In the **last six months**, have you used **Champix (Varenicline)** to help you quit smoking?

*Yes ☐ No ☐ Don't know ☐

If 'Yes', how many quit attempts did you try using Champix (Varenicline)? ☐☐ attempts*

For each most recent attempt, please state how long you used Champix for?

	Less than 24 hours	24 hours	1 to 6 days	7 to 14 days	2 to 4 weeks	Longer than 4 weeks	Cannot remember
Most recent Quit attempt	☐	☐	☐	☐	☐	☐	☐

*If more than 1 attempt was made using Champix, please put details in the comment box.

13. How much have you spent on buying additional products to help you stop smoking over the previous six months (not including NRT and drugs on prescription)

Nothing	£1 - £10	£11 - £20	£21 - £30	£31 - £40	£41 - £50	£51 - £100	Over £100
☐	☐	☐	☐	☐	☐	☐	☐

14. How do you travel to your GP surgery/stop smoking clinic? ☐
15. How much have you spent on travel to your GP surgery/stop smoking clinic to help you stop smoking in the last six months? **£** ☐☐☐
16. Do you currently take Recreational Drugs? *Yes ☐ No ☐

☐

*If ‘Yes’ please specify what you take:

how much do you take per week:

If you have any general comments about the study, or this questionnaire, please write them below:

Thank you for taking time to complete this questionnaire

Patient ID number : ☐☐☐

Date: _____/_____/_____

Body Mass Index (BMI) Measurement

Patient's weight (kg) = _____

Patient's height (m) = _____

$$\text{BMI} = \frac{\text{weight}}{\text{Height}} = \frac{\_\_\_\_\_}{\_\_\_\_\_} = \_\_\_\_\_$$