

**University of Florida Student Health Care Center
Quit Smoking Questionnaire**

This form will help us work with you to plan strategies for quitting smoking. Please fill in or check the appropriate blanks.

Name: _____ **UF ID:** _____ **Age:** _____

Phone: _____ **Email:** _____

Referred by: _____

I want to enroll in the QUIT program to receive discounted or free smoking cessation medication.

(See QUIT Program Information Sheet with criteria for enrollment)

Yes

No

If Yes, please sign below to agree to the QUIT Program terms.

If No, you are welcome to meet with a health educator as often as you prefer for QUIT coaching.

Signature: _____ **Date:** _____

1. I plan to quit smoking:

- ___ In the next 30 days
- ___ By the end of this semester
- ___ In the next 6 months
- ___ By the time I graduate _____ (month/year)
- ___ I quit smoking within the last 30 days

2. Have you set a quit date? _____

If yes, when is it? _____

If no, are you interested in setting a quit date? _____

3. On the average, how many days per month do you smoke cigarettes? _____

4. How many cigarettes do you typically smoke **in a day**? _____

5. How many years have you smoked? _____

6. How many minutes after awakening do you smoke your first cigarette? _____

7. On a scale of 1 to 10, how important is it for you to quit smoking in the next 30 days?

(1 = Not at all; 10 = Extremely) _____

8. On a scale of 1 to 10, how confident are you to quit smoking in the next 30 days?

(1 = Not at all; 10 = Extremely) _____

9. What are your main reasons for wanting to quit smoking? (*check all that apply*)

- ___ Health
- ___ Social stigma
- ___ Family/friends' pressure
- ___ Cost
- ___ Self-esteem
- ___ Family history of lung cancer or emphysema
- ___ Other _____

10. What method(s) of quitting will you seriously consider? (*check all that apply*)

- Using medications/patches (Chantix/Wellbutrin)
- Working with a quit coach
- Trying an online self-help program
- Other _____

11. What are your main concerns about quitting? (*check all that concern you*)

- Dealing with stress
- Weight gain
- Fear of failure
- Withdrawal side effects
- Missing the habit/ritual
- Socializing/drinking without cigarettes
- Having no cigarettes after meals
- Being among smokers
- Fear of succeeding "forever"
- Friend(s) smoke
- Other (*Specify*) _____

12. How many times have you attempted to quit smoking in the past? _____

13. If you have ever tried to quit before, think back to your last attempt. Why did you start smoking again? (*check all that apply*)

- I couldn't deal with cravings
- Stress got to me
- I was drinking alcohol
- I missed my cigarettes
- I was with other smokers
- I was gaining weight
- Other (*Specify*) _____

14. How did you learn about the QUIT Program? (*check all that apply*)

- Website
- Alligator Ads
- Alligator Classifieds
- SHCC medical provider
- SHCC mental health counselor
- Friend
- Bus Interior Ad
- Other (*Specify*) _____

15. Have you had a history of cardiovascular disease or a heart attack?

- Yes No

16. Females only: Are you pregnant or is there a chance you could be pregnant at this time?

- Yes No

Thank you!

For office use: Appt: DATE: _____ Time: _____ MM JE SH

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