ZippHealth
MEDICAL PRACTICE

SMOKING QUESTIONNNAIRE

NAME_____FILE NO:_____

TELEPHONE NO:_____EMAIL:_____

KINDLY ANSWER THE FOLLOWING QUESTIONS:

1. For how many years have you smoked? _____
2. How many cigarettes do you smoke per day (approximately)?_____
3. Do you buy you cigarettes daily? Yes?No? How much do they cost?_____
4. Do you buy you cigarettes in a carton? Yes?No? How much does it cost?_____
5. What brand do you currently smoke?_____
6. Have you tried to quit before and if so when last did you stop?_____
7. If you did stop, how did you achieve this?_____
8. What made you start smoking?
9. Have you ever tried any of the following?_____
   Zyban Yes/No – If yes did you have side effects?_____
   Nicotine replacements: Gum Y/N
   Spray Y/N
   Patch Y/N
10. What are your worst triggers that cause you to smoke?_____
11. Does anyone in your household smoke?_____
12. Do you have any form of stress in your life?_____
13. Do you drink alcohol? Little____Average_____More than average_____
14. How much water do you drink daily?_____
15. Do you exercise regularly?_____
16. What are your main concerns about stopping smoking?_____
17. Do you want to quit or do you have to quit?_____
18. Would you be interested in completely natural products to assist with APPETITE: Y/N
    STRESS: Y/N, issues related to quitting: Y/N
19. Is there a medical reason as to why you want to quit? If yes, please specify_____
20. How did you hear about the treatment that we offer?_____
21. Have you ever fainted/lost consciousness after an injection, having blood taken, etc. Yes/No

If you have long hair, please tie it back before the consultation. PLEASE NO CELL PHONES.

Many thanks for completing the questionnaire.

We look forward to improving your health inside and out.