**Smoking Status Questionnaire**

**Name:**

**Date of Birth:**

**Mobile Phone Number:**

**Email:**

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**Please tell us about your smoking habits (Please tick the appropriate boxes)**

Do you smoke? Yes No

**If Yes, what do you primarily smoke:**

Cigarettes Cigar Pipe VAPE

**How many / how much do you smoke a day?**

**Would you like advice on quitting? Yes No**

**Are you an ex-smoker? Yes No**

**When did you quit?**

**How many / how much did you smoke?**