Freedom From Smoking

Registration Form and Questionnaire

AMERICAN LUNG ASSOCIATION®

All information on this questionnaire will be kept confidential. Please print clearly.

Name: ____________________

Address: ____________________

____

City: ____________ State: ______ Zip Code: ________

Home Phone: ____________ Work Phone: ____________

E-mail: ____________________

Education:
- ■ elementary school
- ■ technical school/training
- ■ high school
- ■ college/university

Gender: ____________ Age: ____________

Questionnaire 3 — *Your History of Tobacco Use*

1. At what age did you begin to use tobacco? ____________
2. How many cigarettes do you smoke each day? ____________
3. How many times have you stopped smoking before? ____________
4. What is the longest period of time you have gone without smoking since you first started? ____________

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Questionnaire 3 (continued)	*Your History of Tobacco Use*

5. *Do you use tobacco in any form other than cigarettes? If YES, please check the box below:*

■ *pipe* ■ *cigar* ■ *snuff* ■ *chewing tobacco*

■ *other:* ______________________________

6. *Do your friends, family, or co-workers smoke?*

■ *family* ■ *friends* ■ *people at work* ■ *none of these people*

7. *Are your family members or significant others supporting you to quit?*

	Supporting me	*They don't want me to quit*	*They don't care*	*They don't know*
Husband/wife/partner	■	■	■	■
Children	■	■	■	■
Friends	■	■	■	■
Co-workers	■	■	■	■

8. *How did you learn about the American Lung Association's Freedom From Smoking Clinic?*

■ *newspaper* ■ *radio* ■ *word of mouth* ■ *TV*

■ *Other:* ______________________________

9. *Which of these best describes your race or ethnic group? (Check all that apply.)*

■ *White* ■ *African American* ■ *Hispanic* ■ *Asian/Pacific Islander*

■ *Native American/Alaskan Native* ■ *Other:* ______________________________

■ *I prefer not to answer this question.*