

Date:

Participant ID:
Site ID:

We Can Quit2 Baseline Data Monitoring Form

About this Form

We need to gather background information about each woman on the programme. Your information will be treated with the strictest of confidence. In keeping with national and Trinity College guidelines, we will keep your data in a safe and secure place for 7 years. Only the research team will have access to your data. Your name and contact details will not be used for the study. They will be stored separately and will only be used when a member of the research team contacts you.

Participant information and consent form

Before completing this form, please confirm that you have received, read and understood the **participant information leaflet**?

Yes ☐ No ☐ (if no, make sure to receive and read the leaflet before proceeding)

Before completing this form, please confirm that you have completed the **consent form**?

Yes ☐ No ☐ (if no, make sure to complete the consent form before proceeding)

Have you heard of the We Can Quit programme?

Yes ☐ No ☐

SECTION 1: ABOUT YOU

In this section, we would like to ask some questions about you, your living arrangements and smoking behaviour.

First name:		Surname:	
1. Are you in paid employment? <input type="checkbox"/> Yes full-time <input type="checkbox"/> Yes part-time <input type="checkbox"/> Carer <input type="checkbox"/> No not in paid employment If 'yes', what is your occupation? If 'no', which of the categories below best describes you? <input type="checkbox"/> Unemployed <input type="checkbox"/> Full-time student or pupil <input type="checkbox"/> Sick/disabled and unable to work <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker/full time parent/carers <input type="checkbox"/> Other (write in).....			
2. How would you describe your background (tick one only):	White <input type="checkbox"/> Irish <input type="checkbox"/> Irish Traveller <input type="checkbox"/> Any other White background	Black or Black Irish <input type="checkbox"/> African <input type="checkbox"/> Other Black background	
	Asian or Asian Irish <input type="checkbox"/> Chinese <input type="checkbox"/> Any other Asian background	Other, including mixed background (write in) <input type="checkbox"/> Prefer not to say	

<p>3. Which best describes your education/training?</p> <p><input type="checkbox"/> No formal education/Primary education/Lower Secondary (Junior cert.)</p> <p><input type="checkbox"/> Upper Secondary (Leaving cert.)/Technical or Vocational/Completed Apprenticeship</p> <p><input type="checkbox"/> Degree (Postgraduate Diploma, Masters, PhD)</p>	<p>4. How many people (including yourself) live in your home?</p> <p>Adults (aged 18 or over, include yourself)</p> <p>.....</p> <p>Children (aged 15-18)</p> <p>.....</p> <p>Children (aged 0-14)</p> <p>.....</p>	<p>5. What is your marital status?</p> <p><input type="checkbox"/> Single (never married)</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> In a registered civil partnership</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> Cohabiting</p>
<p>6. Do you have a GP? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>GP Address (if willing to provide)</p> <p>.....</p> <p>.....</p>	<p>7. Do you currently have a full medical card?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you currently have a GP visit only card?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>9. Would you like us to let your GP know you are taking part in this research study?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

SECTION 2: SMOKING

This section asks about your smoking.

<p>10. Are you currently using any of the following to try to help you stop smoking? (Please tick all that apply)</p> <p><input type="checkbox"/> E-cigarette</p> <p><input type="checkbox"/> Nicotine replacement (e.g. patch, gums etc.) bought over the counter</p> <p><input type="checkbox"/> Nicotine replacement prescribed by GP</p> <p><input type="checkbox"/> Champix (varenicline)</p> <p><input type="checkbox"/> Zyban (bupropion)</p> <p><input type="checkbox"/> Attending a HSE stop smoking support group</p> <p><input type="checkbox"/> Attending another support group</p> <p><input type="checkbox"/> HSE online support – Quit.ie</p> <p><input type="checkbox"/> HSE Quitline – 1800 201 203</p> <p><input type="checkbox"/> Attending a stop smoking clinic (HSE)</p> <p><input type="checkbox"/> No, I am not using any help</p> <p><input type="checkbox"/> Other (describe).....</p>	<p>10. Why do you smoke?</p> <p><input type="checkbox"/> Mainly for pleasure</p> <p><input type="checkbox"/> For pleasure and to cope</p> <p><input type="checkbox"/> Mainly to cope</p> <p><input type="checkbox"/> Other (write in)</p> <p>.....</p> <p>11. How long have you been smoking?</p> <p><input type="checkbox"/> More than 25 years</p> <p><input type="checkbox"/> Between 15-25 years</p> <p><input type="checkbox"/> Between 10 and 15 years</p> <p><input type="checkbox"/> Between 5 and 10 years</p> <p><input type="checkbox"/> Less than 5 years</p>	<p>12. On average, how many cigarettes do you usually smoke per day?</p> <p><input type="text"/> <input type="text"/> cigarettes per day</p> <p><i>To be filled in by researcher:</i></p> <p><input type="checkbox"/> 10 or less</p> <p><input type="checkbox"/> 11-20</p> <p><input type="checkbox"/> 21-30</p> <p><input type="checkbox"/> 31 or more</p>
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13. How soon after you wake up do you smoke your first cigarette? <input type="checkbox"/> Within 5 minutes <input type="checkbox"/> 6-30 minutes <input type="checkbox"/> 31-60 minutes <input type="checkbox"/> after 60 minutes	14. Do you smoke indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. How determined are you to give up smoking at this attempt? <input type="checkbox"/> Not at all determined <input type="checkbox"/> Quite determined <input type="checkbox"/> Very determined <input type="checkbox"/> Extremely determined																					
16. Does anyone that you live with smoke regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply to me If Yes – who? <i>(please tick all that apply)</i> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Yes</th> <th style="width: 20%; text-align: center;">No</th> </tr> <tr> <td><input type="checkbox"/> Spouse/partner</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Child</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Parent</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Sister/brother</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Flatmate</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other <i>(write in)</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>			Yes	No	<input type="checkbox"/> Spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sister/brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Flatmate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other <i>(write in)</i>	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you have anyone who will support you to stop smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes - who? <i>(please tick all that apply)</i> <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Family member <input type="checkbox"/> Friend <input type="checkbox"/> Work colleagues <input type="checkbox"/> Other <i>(write in)</i>
	Yes	No																					
<input type="checkbox"/> Spouse/partner	<input type="checkbox"/>	<input type="checkbox"/>																					
<input type="checkbox"/> Child	<input type="checkbox"/>	<input type="checkbox"/>																					
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<input type="checkbox"/> Other <i>(write in)</i>	<input type="checkbox"/>	<input type="checkbox"/>																					

SECTION 3: YOUR GENERAL HEALTH AND WELLBEING

Just a few questions about your general health and wellbeing.

<p>The following questions ask for your views about your health, how you feel and how well you are able to do your usual activities.</p> <p>If you are unsure about how to answer any questions, please give the best answer you can and make any of your own comments if you like. Do not spend too much time in answering as your immediate response is likely to be the most accurate.</p>				
18. In general, would you say your health is <i>(Please tick one box)</i>				
Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEALTH AND DAILY ACTIVITIES				
<p>The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? <i>(please tick one box)</i></p>				
	Yes, limited a lot	Yes, limited a little	No, not limited at all	
19. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health <i>(Please answer Yes or No to each question)</i>						
	Yes		No			
21. Accomplished less than you would like	<input type="checkbox"/>		<input type="checkbox"/>			
22. Were limited in the kind of work or other activities	<input type="checkbox"/>		<input type="checkbox"/>			
During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? <i>(Please answer Yes or No to each question)</i>						
	Yes		No			
23. Accomplished less than you would like	<input type="checkbox"/>		<input type="checkbox"/>			
24. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>		<input type="checkbox"/>			
25. During the past 4 weeks, how much did pain interfere with your normal work (including work both outside the home and housework)? <i>(Please tick one box)</i>						
Not at all	A little bit	Moderately	Quite a bit	Extremely		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
These questions are about how you feel and how things have been with you during the past month. For each question, please give the one answer that comes closest to the way you have been feeling. <i>(Please tick one box on each line)</i>						
How much of the time during the last month:	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
26. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you felt downhearted and low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Has your health limited your social activities (like visiting friends or close relatives)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form completed by: Name: Role: <input type="checkbox"/> ICS Staff <input type="checkbox"/> Researcher <input type="checkbox"/> Participant <input type="checkbox"/> Other (write in.....)						

Date:

Participant ID:
Site ID:

1

12 Week We Can Quit2 Follow-Up

SECTION 1: ABOUT THE PROGRAMME

Participant Name:	
Actual Quit Date: (dd/mm/yyyy) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Comments:	
1. Have you stopped smoking? Yes – and I'm still not smoking <input type="checkbox"/> <i>Go to Question 2</i> No – I smoke but I have cut down <input type="checkbox"/> <i>Go to Question 3</i> Yes – but I relapsed <i>Go to Question 4</i> <input type="checkbox"/> No – I still smoke <i>Go to Question 5</i> <input type="checkbox"/>	2. If you have stopped smoking, how long has it been since your most recent quit date? <input type="text"/> days <input type="text"/> weeks <i>Go to Question 4</i>
3. Have you cut down since starting the programme? <input type="text"/> Yes <input type="text"/> No How many cigarettes a day do you now smoke? <input type="text"/> cigarettes <i>Go to Question 5</i>	4. If you stopped smoking and relapsed, how long did you stop for? <input type="text"/> days <input type="text"/> weeks What was the main reason for your relapse? What helped you get back on track?
5. Are you using e-cigarettes? <input type="text"/> Yes <input type="text"/> No If yes, for how long in total have you been using e-cigarettes? <input type="text"/> days <input type="text"/> weeks	6. What helped you most in trying to stop smoking? (please tick all that apply) NRT <input type="checkbox"/> Group support <input type="checkbox"/> One-to-one support <input type="checkbox"/> Other (please list below): <input type="checkbox"/>
7. Did you receive a NRT prescription from your GP? <input type="text"/> Yes <input type="text"/> No <input type="text"/> Not applicable	8. Did you receive NRT directly from pharmacy without prescription? <input type="text"/> Yes <input type="text"/> No <input type="text"/> Not applicable
9. How many weeks was NRT prescribed for? <input type="text"/> weeks <input type="text"/> Not applicable	10. Did you keep to the NRT dosage that was prescribed? (For example, 21 mg or 14 mg patches)

1

<p>Did you use it for the full length of time that it was prescribed for?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable </p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable </p> <p>Comments:</p>																
<p>11. Did you use a single NRT product or combination (2 types or more)?</p> <p> <input type="checkbox"/> Single <input type="checkbox"/> Combination <input type="checkbox"/> Not applicable </p>	<p>12. Which type of NRT/other medication did you use?</p> <p>(see list below and write in code):</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <p>Please use numbers to show if more than one medication is used consecutively (e.g. NRT Patch is used as well as inhalator would be coded as 2 & 4)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>None</td><td>Code 1</td></tr> <tr><td>NRT-Patch</td><td>Code 2</td></tr> <tr><td>NRT-Gum</td><td>Code 3</td></tr> <tr><td>NRT – Inhalator</td><td>Code 4</td></tr> <tr><td>NRT – Lozenge</td><td>Code 5</td></tr> <tr><td>NRT – Mist Spray</td><td>Code 6</td></tr> <tr><td>Champix</td><td>Code 7</td></tr> <tr><td>Zyban</td><td>Code 8</td></tr> </table>	None	Code 1	NRT-Patch	Code 2	NRT-Gum	Code 3	NRT – Inhalator	Code 4	NRT – Lozenge	Code 5	NRT – Mist Spray	Code 6	Champix	Code 7	Zyban	Code 8
None	Code 1																
NRT-Patch	Code 2																
NRT-Gum	Code 3																
NRT – Inhalator	Code 4																
NRT – Lozenge	Code 5																
NRT – Mist Spray	Code 6																
Champix	Code 7																
Zyban	Code 8																
<p>13. Which type of behavioural support did you receive? (see list below and write in code):</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Group</td><td>Code 1</td></tr> <tr><td>One-to-one face-to-face support</td><td>Code 2</td></tr> <tr><td>Text message</td><td>Code 3</td></tr> <tr><td>Telephone Support</td><td>Code 4</td></tr> <tr><td>Advice on NRT and letter for GP</td><td>Code 5</td></tr> <tr><td>Other</td><td>Code 6</td></tr> <tr><td> </td><td> </td></tr> </table>	Group	Code 1	One-to-one face-to-face support	Code 2	Text message	Code 3	Telephone Support	Code 4	Advice on NRT and letter for GP	Code 5	Other	Code 6			<p>14. Did you receive group support?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>15. If YES , how many group sessions did you attend:</p> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin-right: 10px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <p>16. How long did the group sessions last on average</p> <ol style="list-style-type: none"> 1. 0-30 minutes <input type="checkbox"/> 2. 31-60 minutes <input type="checkbox"/> 3. 61-90 minutes <input type="checkbox"/> 4. over 90 minutes <input type="checkbox"/> 		
Group	Code 1																
One-to-one face-to-face support	Code 2																
Text message	Code 3																
Telephone Support	Code 4																
Advice on NRT and letter for GP	Code 5																
Other	Code 6																
<p>17. Did you receive one-to-one support, i.e. individual support?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If so, what type of support did you receive?</p> <p>(please tick <i>all</i> that apply)</p> <p>Face-to-face meeting <input type="checkbox"/></p> <p>Telephone support <input type="checkbox"/></p> <p>Email support <input type="checkbox"/></p> <p>Text support <input type="checkbox"/></p> <p>None <input type="checkbox"/></p> <p>Other: _____</p>	<p>18. How many face to face meetings did you attend?</p> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin-right: 10px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <p>19. How long did the face to face sessions last on average?</p> <ol style="list-style-type: none"> 1. 0-15 minutes <input type="checkbox"/> 2. 16-30 minutes <input type="checkbox"/> 3. 31-60 minutes <input type="checkbox"/> 4. 61-90 minutes <input type="checkbox"/> 5. Over 90 minutes <input type="checkbox"/> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>20. Were you given information to bring home to read/go through? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																

		21. What was this? (<i>passport to quit</i>) Write in.....			
How satisfied were you with the following: <i>(please tick one box per question)</i>	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
22. Registration process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Consent process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Support received from facilitators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Follow-up process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Length of the programme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
27. How comfortable were you with your saliva sample being taken? <div> <input type="checkbox"/> Very comfortable <input type="checkbox"/> Comfortable <input type="checkbox"/> Unsure <input type="checkbox"/> Uncomfortable <input type="checkbox"/> Very uncomfortable </div> Comments:					
28. Who was your facilitator (<i>code only to be recorded</i>):					
29. CO reading: <div> <input type="text"/> <input type="checkbox"/> Refused to give sample </div>			30. Saliva sample taken: <div> <input type="checkbox"/> Yes <input type="checkbox"/> No, still smoking <input type="checkbox"/> No, refused to give sample </div>		

SECTION 2: YOUR GENERAL HEALTH AND WELLBEING

Just a few questions about your general health and wellbeing.

The following questions ask for your views about your health, how you feel and how well you are able to do your usual activities.

If you are unsure about how to answer any questions, please give the best answer you can and make any of your own comments if you like. Do not spend too much time in answering as your immediate response is likely to be the most accurate.

31. In general, would you say your health is *(Please tick one box)*

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH AND DAILY ACTIVITIES

The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? *(please tick one box)*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
32. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health *(Please answer Yes or No to each question)*

	Yes	No
34. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
35. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? *(Please answer Yes or No to each question)*

	Yes	No
36. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
37. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

38. During the past 4 weeks, how much did pain interfere with your normal work (including work both outside the home and housework)? (Please tick one box)						
Not at all	A little bit	Moderately	Quite a bit	Extremely		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
These questions are about how you feel and how things have been with you during the past month. For each question, please give the one answer that comes closest to the way you have been feeling. (Please tick one box on each line)						
How much of the time during the last month:	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
39. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Have you felt downhearted and low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Has your health limited your social activities (like visiting friends or close relatives)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form completed by:						
Name:						
Role: <input type="checkbox"/> Researcher <input type="checkbox"/> ICS staff <input type="checkbox"/> Participant <input type="checkbox"/> Other (write)						
Date:						

Date:

Participant ID:

Site ID:

6 Month We Can Quit2 Follow-Up

SECTION 1: ABOUT THE PROGRAMME

Participant Name:

Actual Quit Date:

(dd/mm/yyyy)

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1. Have you received any support since the stop smoking programme ended?

☐ Yes

☐ No

If so, what type of support did you receive? (please tick **all** that apply)

		Number of sessions
Face-to-face meeting	<input type="checkbox"/>	<input type="text"/>
Telephone support	<input type="checkbox"/>	<input type="text"/>
Email support	<input type="checkbox"/>	<input type="text"/>
Text support	<input type="checkbox"/>	<input type="text"/>
NRT	<input type="checkbox"/>	<input type="text"/>
None	<input type="checkbox"/>	<input type="text"/>
Other (please list below):	<input type="checkbox"/>	<input type="text"/>

Comments:

2. Have you stopped smoking?

Yes – and I'm still not smoking ☐

Go to Question 3

No – I smoke but I have cut down ☐

Go to Question 4

Yes – but I relapsed ☐

Go to Question 5

No – I still smoke ☐

Go to Question 6

3. If you have stopped smoking, how long has it been since your most recent quit date?

days weeks

Go to Question 6

4. Have you cut down since starting the programme?

☐ Yes

☐ No

How many cigarettes a day do you now smoke?

cigarettes

Go to Question 6

5. If you stopped smoking and relapsed, how long did you stop for?

days weeks

What was the main reason for your relapse?

.....

What helped you get back on track?

.....

<p>6. Are you using e-cigarettes?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If yes, for how long in total have you been using e-cigarettes?</p> <p> <input style="width: 50px;" type="text"/> days <input style="width: 50px;" type="text"/> weeks </p>	<p>7. What helped you most in trying to stop smoking? (please tick all that apply)</p> <p> NRT <input type="checkbox"/> Group support <input type="checkbox"/> One-to-one support <input type="checkbox"/> Other (please list below): <input type="checkbox"/> </p> <p>_____</p>
<p>8. How important was the incentive, i.e. the voucher, in deciding to take part in the follow-up?</p> <p> <input type="checkbox"/> Very important <input type="checkbox"/> Important <input type="checkbox"/> Neither important nor unimportant <input type="checkbox"/> Unimportant <input type="checkbox"/> Very unimportant </p> <p>Please explain:</p>	
<p>9. Saliva sample taken:</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No, still smoking <input type="checkbox"/> No, refused to give sample </p>	

SECTION 2: YOUR GENERAL HEALTH AND WELLBEING

Just a few questions about your general health and wellbeing.

<p>The following questions ask for your views about your health, how you feel and how well you are able to do your usual activities.</p> <p>If you are unsure about how to answer any questions, please give the best answer you can and make any of your own comments if you like. Do not spend too much time in answering as your immediate response is likely to be the most accurate.</p>				
<p>10. In general, would you say your health is (Please tick one box)</p>				
Excellent <input type="checkbox"/>	Very good <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
<p>HEALTH AND DAILY ACTIVITIES</p> <p>The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? (please tick one box)</p>				
	Yes, limited a lot <input type="checkbox"/>	Yes, limited a little <input type="checkbox"/>	No, not limited at all <input type="checkbox"/>	
11. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health <i>(Please answer Yes or No to each question)</i>						
	Yes		No			
13. Accomplished less than you would like	<input type="checkbox"/>		<input type="checkbox"/>			
14. Were limited in the kind of work or other activities	<input type="checkbox"/>		<input type="checkbox"/>			
During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)? <i>(Please answer Yes or No to each question)</i>						
	Yes		No			
15. Accomplished less than you would like	<input type="checkbox"/>		<input type="checkbox"/>			
16. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>		<input type="checkbox"/>			
17. During the past 4 weeks, how much did pain interfere with your normal work (including work both outside the home and housework)? <i>(Please tick one box)</i>						
Not at all	A little bit	Moderately	Quite a bit	Extremely		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
These questions are about how you feel and how things have been with you during the past month. For each question, please give the one answer that comes closest to the way you have been feeling. <i>(Please tick one box on each line)</i>						
How much of the time during the last month:	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
18. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you felt downhearted and low?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has your health limited your social activities (like visiting friends or close relatives)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form completed by:						
Name:						
Role: <input type="checkbox"/> Researcher <input type="checkbox"/> ICS staff <input type="checkbox"/> Participant <input type="checkbox"/> Other (write)						
Date:						