



Maryland teens rejecting abusive smoking habits

www.marylandtrash.com

Maryland TRASH Quit Kit Ordering Form (page 1 of 4)

YOUR CONTACT INFORMATION

Your First Name _____
 Your Last Name _____
 Your Mailing Address _____
 City _____
 Maryland County _____
 State _____
 Zip Code _____
 Contact Phone No. _____
 Contact E-mail _____

Please be sure to enter your e-mail address correctly in the required form field. A confirmation e-mail will be sent to you which requires your reply to receive the kit.

Your Age Group (please circle one)

12 or younger 13 14
 15 16 17 18

Under the Federal Trade Commission Children's Online Privacy Protection Rule, contact information cannot be collected for youth under 13 years old. If you are under 13 and would like to receive a kit, please call us at (410) 767-5316.

How did you hear about the Quit Kit? _____

Please tell us how this kit will be used: _____

RECIPIENT INFORMATION

Recipient First Name _____
 Recipient Last Name _____
 Recipient Mailing Address _____
 City _____
 Maryland County _____
 State _____
 Zip Code _____
 Recipient Phone No. _____
 Recipient Contact E-mail _____

Recipient's Age Group (please circle one)

12 or younger 13 14
 15 16 17 18

Under the Federal Trade Commission Children's Online Privacy Protection Rule, contact information cannot be collected for youth under 13 years old. If you are under 13 and would like to receive a kit please call us at (410) 767-5316.

Please send the Maryland TRASH Quit Kit to Recipient I would like to give the recipient the kit myself; please send the Maryland TRASH Quit Kit to my mailing address.

SMOKING HISTORY

Please complete the following questionnaire to help us understand more about smokers. This form should be filled out by the person who intends to use the kit to quit smoking. All fields required unless otherwise noted.

1. How old were you when you first started smoking fairly regularly? (Regularly in this instance would be considered 5 out of 7 days in a week)
 _____ Age

2. Have you ever smoked at least one cigarette every day for 30 days consecutively?
 Yes
 No

3. What is the total number of years during which you have smoked every day? (If Less than one year, enter "less than one year")
 _____ Years

4. During the past 30 days, on how many days did you smoke cigarettes?
 _____ Days

Please continue to the next page.



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5. On average, when you smoked during the past 30 days, about how many cigarettes did you smoke a day?
____ Cigarettes
6. For approximately how many years have you been smoking this many cigarettes?
____ Years
7. How long can you go without smoking before you feel like you need a cigarette?
- Less than one hour
 - 1 to 3 hours
 - More than 3 hours but less than a day
 - A whole day
 - Several days
 - A week or more
8. How true is this statement for you? When I go without a smoke for a few hours, I experience a craving.
- Not true at all
 - Not very true
 - Fairly true
 - Very true
9. Do people you live with or know well smoke? Parents(s), sisters/brothers, friends, boy/girl friend, etc.)
- Yes
 - No
10. In your life, how many times have you stopped smoking cigarettes for one day or longer because you were trying to quit?
If this is the first time, please skip to question 16.
____ Number of times
11. Of all the times you have tried to quit, what was the longest period you stayed off of cigarettes?
____ Number of weeks / months / years
12. During the past 12 months have you stopped smoking cigarettes for one day or longer because you were trying to quit?
- Yes
 - No
13. The last time you tried to quit smoking did you use something to help you quit?
- Yes
 - No
14. Which of the following medications, products, and/or programs did you use when you tried to quit smoking? Were these of help to you?
- | | | |
|-------------------------------|---------------------------------|--|
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | Nicotine patch, gum, nasal spray or inhaler |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | Zyban, or other non-nicotine prescription medicine |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | A quit smoking class or group |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | A quit smoking telephone help line |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | Hypnosis |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | Acupuncture |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | Self-help materials |
| <input type="checkbox"/> Used | <input type="checkbox"/> Helped | Other (please specify) _____ |



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15. People have variety of reasons for starting to smoke again after they have tried to quit. From the list below, mark the ONE biggest reason why you started to smoke again after your last attempt to quit smoking.

- Fear of gaining weight
- Actual weight gain
- Headaches, irritability, difficulty concentrating, drowsiness
- Bored, blue, depressed
- Nervous, tense, angry, frustrated, stressed
- Stressful life event
- Pressure from others to smoke
- No support from others
- Habit, situation where you used to smoke regularly
- Addiction, craving
- Pleasure of smoking, enjoy it
- Others smoking around me
- Not ready to quit, didn't want to quit
- Didn't try hard enough, no will power
- Like to smoke when drinking alcohol

16. What were some reasons you started smoking?

- Friends smoked
- Parents smoked
- Wanted to lose weight
- Thought it was cool

17. What has motivated you to quit smoking?

- Health reasons
- Boy/Girl friend asked me to
- Parents asked me to
- I'm just ready

18. Have you tried/used any of the following? (Regularly in this instance would be considered 5 out of 7 days in a week)

- | | | | | |
|---|------------|-------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Spit/smokeless tobacco | How often? | <input type="checkbox"/> Once | <input type="checkbox"/> A few times | <input type="checkbox"/> Regularly |
| <input type="checkbox"/> Light cigarettes | How often? | <input type="checkbox"/> Once | <input type="checkbox"/> A few times | <input type="checkbox"/> Regularly |
| <input type="checkbox"/> Alcohol | How often? | <input type="checkbox"/> Once | <input type="checkbox"/> A few times | <input type="checkbox"/> Regularly |
| <input type="checkbox"/> Drugs | How often? | <input type="checkbox"/> Once | <input type="checkbox"/> A few times | <input type="checkbox"/> Regularly |

19. Where do you most often encounter other people smoking?

- School
- Home
- Parties
- Other (please specify) _____

20. What type of cigarettes do you smoke?

- Low nicotine (≤ 0.9 mg)
- Medium nicotine (1-1.2 mg)
- High nicotine (≥ 1.3 mg)



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21. How often do you inhale the smoke?

- Never
- Sometimes
- Always

22. How soon after you wake up do you smoke your first cigarette?

- < 5 minutes
- 6-30 minutes
- 31-60 minutes
- After one hour

23. Do you smoke more during the first 2 hours you're awake than the rest of the day?

- Yes
- No

24. Which cigarette would you most hate to give up?

- The first one in the morning
- Any other than the first one

25. Do you find it difficult to refrain from smoking in places where it is forbidden (planes, public buildings, school)?

- Yes
- No

26. Do you still smoke even when you are so ill that you are in bed most of the day?

- Yes
- No

Thank you for taking the first step to a healthier life!

We respect your privacy. The information collected on this form will only be used by Maryland TRASH to improve the Web site experience and to keep track of how effective our efforts are at curbing tobacco use. We won't sell your info.

Please send this form to:

Maryland Department of Health and Mental Hygiene
Center for Health Promotion, Education & Tobacco Use Prevention
ATT: Dana Moncrief
201 W. Preston Street
Baltimore, MD 21201

Questions? Call 410.767.5316