WE ARE TRYING TO UPDATE OUR COMPUTER RECORDS AND WOULD BE GRATEFUL IF YOU COULD TAKE A LITTLE TIME TO COMPLETE THE ATTACHED FORM.
PLEASE HAND FORM BACK TO RECEPTIONIST OR GP/NURSE

NAME			
ADDRESS			
DATE OF BIRTH			
TELEPHONE NUMBER		MOBILE TEL NO	

SMOKING STATUS

SMOKER	YES/NO	NUMBER SMOKED PER DAY	
NEVER SMOKED			
EX SMOKER			

IF YOU ARE A SMOKER – HAVE YOU CONSIDERED STOPPING?

SMOKING CESSATION ADVICE IS AVAILABLE FROM YOUR GP, PRACTICE NURSE AND LOCAL PHARMACIST

MRS P SMITH
PRACTICE MANAGER