

TOBACCO USE AMONG HEALTH CARE WORKERS QUESTIONNAIRE

Dear Colleague,

Smoking is a major public health issue in Saudi Arabia today, and we are very interested in study how HCWs in the region like you feel towards smoking and health.

This will take no more than five minutes of your time.

Guidelines

This questionnaire is about your **own opinion**. You should provide the answers that *you* think are right. Also, you are *not* expected to know everything. If you feel that you cannot answer a question, just check "I do not know". You are also free to refuse to answer any question.

Confidentiality

We will keep your responses strictly confidential, and the questionnaire is anonymous.

Have you ever smoked?

- | | |
|--|-----------------|
| <input type="checkbox"/> NO, I have never smoked | Go to Section B |
| <input type="checkbox"/> YES, I have smoked | Go to Section A |

Are you still smoking?

- | | |
|--|-----------------|
| <input type="checkbox"/> NO, I am a former smoker (have smoked, but currently do not smoke). | Go to Section B |
| <input type="checkbox"/> Yes, I am a regular or occasional smoker | Go To Section A |

Section A : Questions for smokers

Please answer the following section if you are a smoker, even an occasional one.

Tobacco use

- | | | |
|-------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Cigars | <input type="checkbox"/> Water pipe |
|-------------------------------------|---------------------------------|-------------------------------------|

On average, how many cigarettes do you smoke every day?

- | | | |
|---|---------------------------------|---------------------------------------|
| <input type="checkbox"/> I am an occasional smoker who does not smoke every day | | |
| <input type="checkbox"/> 1- 5 | <input type="checkbox"/> 6 – 10 | <input type="checkbox"/> More than 10 |

Do you have other smoking habits?

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> No I do not | <input type="checkbox"/> I smoke cigars | <input type="checkbox"/> I smoke water pipes |
|--------------------------------------|---|--|

Do you regularly smoke in front of your patients? ☐ No ☐ yes

What do you get from smoking?

- | | |
|--|---|
| <input type="checkbox"/> It relaxes me | <input type="checkbox"/> It helps me to concentrate |
| <input type="checkbox"/> It is an excuse for a break at work | |
| <input type="checkbox"/> It gives me a confidence | <input type="checkbox"/> Others: |

Thinking about the reasons or situations why and when you smoke now, please circle the three which most apply to you from the following list, or substitute for your own.

I smoke more when I am:

- | | | | |
|------------------------------------|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Stressed | <input type="checkbox"/> Angry | <input type="checkbox"/> Lonely | <input type="checkbox"/> Bored |
| <input type="checkbox"/> Upset | <input type="checkbox"/> Talking on the telephone | <input type="checkbox"/> Driving | |
| <input type="checkbox"/> Relaxing | <input type="checkbox"/> Socializing | <input type="checkbox"/> Thinking | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> To escape pressure | <input type="checkbox"/> Talking | |
| <input type="checkbox"/> Walking | <input type="checkbox"/> After meals | <input type="checkbox"/> Happy | |

How old were you when you started smoking?..... years

Why did you start smoking?

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Appear older | <input type="checkbox"/> Appear "cool" | <input type="checkbox"/> Curiosity |
| <input type="checkbox"/> Appear tough/macho | <input type="checkbox"/> Be accepted | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Just felt like it | <input type="checkbox"/> Copy friends/family | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Feel grown up | <input type="checkbox"/> Out of boredom | |

How do you feel about quitting smoking?

- ☐ I would like to quit smoking ☐ I believe I can quit smoking anytime
- ☐ I do not like to quit smoking

How interested are you in stopping smoking? (Please check one.)

- | | | |
|-----------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Strongly | <input type="checkbox"/> Somewhat | <input type="checkbox"/> not at all |
|-----------------------------------|-----------------------------------|-------------------------------------|

How many times have you tried to stop smoking? (Please check one.)

- | | | |
|--------------------------------|-------------------------------|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> One | <input type="checkbox"/> Two |
| <input type="checkbox"/> Three | <input type="checkbox"/> Four | <input type="checkbox"/> Five and more |

What could motivate you to quit smoking?

- | | | |
|--|---|--|
| <input type="checkbox"/> Health issues | <input type="checkbox"/> The cost of cigarettes | <input type="checkbox"/> Another reason (please specify):..... |
|--|---|--|

Which of the following do you consider to be important obstacles to you quitting smoking?

- ☐ I find it tempting when I see my family or my friends smoke
- ☐ Independently from others, I feel personally addicted to the habit of smoking
- ☐ I am afraid of the physical consequences quitting could have on me
- ☐ Another obstacle (please specify):.....

Section B

About yourself

Please answer ALL the following questions.

Reminder: all your responses are anonymous and kept confidential.

How old are you? Years

Currently you are working in.....as:.....

Nationality:

Marital Status:

- ☐ Single ☐ Married
☐ Widowed ☐ Divorced

Place of Birth:

- ☐ Village
☐ Small City
☐ Large City

History of Parental Smoking: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Thank you for completing this questionnaire.