MED-WORLD
PHARMACY
& Compounding Center

INFORMATION WAIVER for Group Class

Disclaimer: You are taking part in this class to stop smoking as a group setting. Be aware that information or stories shared in this class will be overheard by those around you. Med-World Pharmacy, nor any of its associates, can control the use of personal health information shared in the group setting by members of the group, and therefore cannot be held liable.

If you choose to use prescription products on your journey to quit smoking, we will need to request a prescription from your doctor. Your information will be shared with your doctor as it would be if we were asking for any other medication.

Participant Signature: _____Date: _____

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Smoking History Questionnaire

Name: **How did you hear about us:_____**

Date of Birth:

Phone Number: **Text messages? Yes No**

E-mail Address:

Preferred form of Communication: Phone Text E-mail

Do you have insurance for prescription? Yes No What company? _____

Do you have seizures or are you taking a medication to prevent seizures?
Yes No If yes, what is the date of your last seizure? _____

At what age did you first start smoking?

_____

How many cigarettes do you smoke a day? When do you smoke during the day?

_____

Have you tried quitting before, if so what methods did you try?

_____

_____

Does anyone that you live with smoke?

_____

What is your commitment to giving up smoking on a scale of 1 to 10 (1 being the least, to 10 being greatest)?

_____

Why have you chosen to stop smoking now?

_____

_____