Client Assessment Form for Varenicline

As you have chosen to consider Varenicline as your medication to help stop smoking, please complete the questions below. As it has already been discussed with you, treatment with Varenidine may have side effects. This medicine may not be appropriate for you if you have certain medical conditions. If you do not want to answer a question or want to speak to a smoking advisor/pharmacist confidentially, please highlight this to the pharmacist.

If you are commenced on Varenicline a letter will be sent to your GP to inform them. They will be asked to contact us if they have any concerns with you receiving the treatment.

Social History	
In a week how many units would you drink?	Units
1 Unit = half a pint, 1 unit = 125ml (small glass of wine), 1 unit = single me	asure of a spirit
Past Medical History	
Do you have a history of feeling depressed, low in mood?	Yes/no
Have you ever been diagnosed with bipolar disorder?	Yes/No
Have you ever been prescribed medication for low mood, depressions or	
E.g. antidepressants	Yes/No
Have you ever been diagnosed with a seizure (fits) disorder?	Yes/No
Have you ever been diagnosed with an eating disorder?	Yes/No
Current Medical History	
During the last month, have you often been bothered by feeling down, de	epressed or hopeless? Yes/No
During the last month have you often been bothered by having little interdoing things	rest or pleasure in Yes/No
Do you have reduced kidney function? (also called renal impairment)	Yes/No
Medical History Please provide a list of your current medications to the advisor for informated commented in your management plan). Please include medicines that you plus any herbal products or vitamins you are taking.	buy from a pharmacy
Patient Name (please print)	
Signature Date I confirm that the information provided is a true reflection and allows the C	

provide the most appropriate, most safe advice and treatment for me