

S3 Text. Baseline structured questionnaire

Code : _____ Date : _____ Hospitals: _____

Instruction:

This questionnaire is used to collect the smoking-related information of smoking expectant fathers. All contents are anonymous and will be kept by a dedicated person to ensure the confidential. Please mark "✓" in the appropriate "☐" or fill in the content that suits your situation on "_____".

Part One: Smoking status

A1. Have you smoked each day in the past month? 1. Yes

0. No

A-1-1. Average _____ Cigarettes /day

A-1-0. In the past 30 days: (Please fill in the specific number on the line)

How many days do you smoke from Monday to Friday?

Average _____ days/week, Average _____ Cigarettes /day

How many days do you smoke from Saturday to Sunday?

Average _____ days/week, Average _____ Cigarettes /day

A2. When did you firstly attempt to use cigarette? _____ years

(Please fill in the specific number on the line)

A3. How old do you start smoking at least one cigarette a month? _____ years

A4. Do you use e-cigarettes in the past month? 1. Yes

0. No (Go to A6)

A5. Does the e-cigarette you used contain nicotine ingredients?

1. Yes

0. No

9. Don't know

A6. Do you use heated tobacco products in the past month? 1. Yes

0. No

A7. Do you use any other tobacco products in the past month except for traditional cigarettes, electronic cigarettes or heated cigarettes?

0. No (Go to A9)

1. Yes, It's _____ (Please fill the category of the tobacco products)

A8. How many such tobacco products have you used in the past month?

A total of _____ times, a total of _____ units (please fill in the specific number on the line)

A9. Biochemical validated smoking status

Exhaled CO level-

Reference : ≥ 4 ppm

B1. How soon after waking do you smoke your first cigarette?

3. Within 5 mins 2. 6-30 mins 1. 31-60 mins 0. 60 mins later

B2. Do you find it difficult to refrain from smoking places where it is forbidden? E.g. Church, Library, etc.

1. Yes 0. No

B3. Which cigarette would you hate to give up?

1. The First in the morning 0. Any other

B4. How many cigarette a day do you smoke?

0. 10 or less

1. 11-20

2. 21-30

3. 31 or more

B5. Do you smoke more frequently in the morning?

1. Yes

0. No

B6. Do you smoke even if you are sick in most of the day?

1. Yes

0. No

0To be completed by researcher: Total score: _____

Nicotine Dependency: 1. Mild (0-3)

2. Moderate (4-5)

3. Severe (6-10)

Part Two: Quit history

- C1. How many times have you attempted to quit smoking for more than 24 hours in the past year?
 0. No attempt (Go to D1) 1. Yes, I attempted _____ times (Please fill in the specific number on the line)
- C2. How long have you sustained to no smoke? _____ days (Please fill in the specific number on the line)
- C3. When was the last time you tried to quit smoking? _____ (Please fill in the specific date on the line)
- C4. Do you plan to quit smoking now? 1. Yes 0. No (Pre-contemplation) (Go to D1)
- C5. When do you plan to quit smoking? (Single choice)
- 0. I have no smoking now (action)
 - 1. I will quit smoking within 7 days (preparation/contemplation)
 - 2. I will quit smoking within 1 month (preparation/contemplation)
 - 3. I will quit smoking within 6 months (contemplation)
 - 4. I will quit smoking after 6 months (pre-contemplation)
 - 5. Have not made a decision yet (pre-contemplation)
- C6. 1. Decided smoking cessation date _____ 0. Undecided smoking cessation date

The exact time
 i) ___ days after; or
 ii) ___ months after.

0 Stage of readiness to quit smoking:
 Action Preparation# Contemplation# Pre-contemplation
 # **Preparation:** At least one 24-hour quit attempt in the past year; **Contemplation:** No quit attempt

Part Three: Family situation

- D1. How many children do you currently have? _____ (Please fill in specific numbers on the line)
- D2. How many smokers you are living with? _____ (Please fill in specific numbers on the line).
 Does your partner smoke?
 1. She is a current smoker 2. She smoked before, but quitted now 0. She never smoked

Part Four: Self-efficacy against tobacco use

E. The following are some situations in which certain people might be tempted to smoke. Please indicate whether you are sure that you could refrain from smoking in each situation using one of the following answers:

	1 Not at all sure	2 Not very sure	3 More or less sure	4 Fairly sure	5 Absolutely sure
1. When I feel nervous.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When I feel depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When I am angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. When I feel very anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When I want to think about a difficult problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. When I feel the urge to smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. When having a drink with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. When celebrating something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. When drinking beer, wine, or other spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. When I am with smokers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. After a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. When having coffee or tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part Five: Health Status

F1. Do you drink? 1. Yes, the frequency was about: 0. No, I never drink (Go to F2)

- | | |
|--|--|
| 0. <input type="checkbox"/> Drink occasionally | 1. <input type="checkbox"/> 1-2 times per month |
| 2. <input type="checkbox"/> 1-2 times per week | 4. <input type="checkbox"/> More than once a day |

F2. Have you done regular physical exercises within the past month? 1. Yes 0. No (Go to F3)

What sport do you do? _____ How often do you do the physical activity? _____ mins/week

F3. In general, would you say your health is:

5. Excellent 4. Very good 3. Good 2. Fair 1. Poor

F4. Within the past year, have you suffered from long-term illness? (Note: Long-term illness means that a certain illness has affected you for a long time or you have been troubled by a certain illness for a long time)

0. Yes 1. No (Go to F6)

F5. If yes, does the long-term illness now limit your daily activities?

0. Yes 1. No

F6. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

F6-1. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

0. Yes, limited a lot 1. Yes, limited a little 2. No, not limited at all

F6-2. Climbing several flights of stairs.

0. Yes, limited a lot 1. Yes, limited a little 2. No, not limited at all

F7. During the past week, have you had accomplished less than you would like with your work or other regular daily activities as a result of your physical health?

0. Yes 1. No

F8. During the past week, have you were limited in the kind of work or other activities as a result of your physical health?

0. Yes 1. No

F9. During the past week, have you had accomplished less than you would like with your work or other regular daily activities as a result of any emotional problems?

0. Yes 1. No

F10. During the past week, have you not done work or other activities as carefully as usual as a result of any emotional problems?

0. Yes 1. No

F11. During the past week, how much did pain interfere with your normal work (including both work outside the home and housework)?

0. Not at all 1. A little bit 2. Moderately
3. Quite a bit 4. Extremely 5. Not applicable

F12. These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

F12-1. How much of the time during the past week have you felt calm and peaceful?

1. All of the time 2. Most of the time 3. A good bit of time
4. Some of the time 5. A little of the time 6. None of the time

F12-2. How much of the time during the past week did you have a lot of energy?

1. All of the time 2. Most of the time 3. A good bit of time
4. Some of the time 5. A little of the time 6. None of the time

F12-2. How much of the time during the past week have you felt downhearted and blue?

1. All of the time 2. Most of the time 3. A good bit of time
4. Some of the time 5. A little of the time 6. None of the time

F12-2. During the past week, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

1. All of the time 2. Most of the time 4. Some of the time
5. A little of the time 6. None of the time

Part Six: The use of smoking cessation services

G1. Have you used any other smoking cessation service in the past year?

1. Yes 0. No (Go to part seven)

G2. What smoking cessation service you have used? (Multiple choices)

- | | No | Yes | (times used) |
|--|--------------------------|--------------------------|--------------|
| 1. <input type="checkbox"/> Telephone counselling | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |
| 2. <input type="checkbox"/> Nicotine replacement treatment | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |
| 3. <input type="checkbox"/> Face to Face counselling | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |
| 4. <input type="checkbox"/> Group discussion | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |
| 5. <input type="checkbox"/> Medication treatment | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |
| 6. <input type="checkbox"/> Acupuncture treatment | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |
| 7. <input type="checkbox"/> Others : _____ | <input type="checkbox"/> | <input type="checkbox"/> | (_____) |

(Please mark)

Part Seven: Demographics information

Name: _____ Birth date: _____ Year _____ Month _____

WeChat Number (QQ) : _____ Contact number: _____

Contacting time preferences : Working day Weekends Both
 Daytime Night Specific time period : _____

H1. What is your highest education level :

1. Primary school or below 2. Junior Secondary school
3. Senior Secondary school 4. Degree or above

H2. What's your current employment status:

1. Employed 2. Self-employed 3. Unemployed

H3. How much is your annually family income

0. 10k or below 1. 10k-50k 2. 50k-100k
3. 100k-200k 4. 200k or above

_____ Thank you for your cooperation! This is the end of the questionnaire _____

基线问卷

编码：_____ 日期：_____ 医院：_____

说明：

该问卷是想了解其妻子已经怀孕的吸烟男性者与吸烟有关的信息，所有内容均为匿名，并且会由专人保管，保证您的信息不会泄露，请在适当的“□”内打“√”，或在“_____”上填写符合您情况的内容。

第一部分：吸烟情况

A1. 您过去一个月是每天吸烟吗？ 1. 是

0. 不是

A-1-1 平均每天抽_____支

A-1-0. 过去的 30 天内：（请在横线上填入具体数字）
周一到周五有几天有吸烟？_____天，平均_____支/天；
周末有几天有吸烟？_____天，平均_____支/天。

A2. 您在几岁的时候吸第一支烟？_____岁
（请在横线上填入具体数字）

A3. 您几岁开始每个月最少吸一支烟呢？_____岁

A4. 您过去一个月有没有使用电子烟？ 1. 有 0. 没有(跳到A6)

A5. 您使用的电子烟含不含尼古丁成分？ 1. 有 0. 没有 9. 不知道

A6. 您过去一个月有没有使用加热烟？ 1. 有 0. 没有

A7. 除了传统烟、电子烟或者加热烟，您过去一个月还有没有使用其他烟草产品？
0. 没有(跳到D部分) 1. 有，是_____（请填入烟草产品）

A8. 你过去一个月有使用多少这种烟草产品？共_____次，共_____个/支（请在横线上填入具体数字）

A9. 生化检测结果

呼吸一氧化碳	参考值：≥ 4 ppm
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B1. 您早晨醒来后多久吸第一支烟？

3. 5 分钟 2. 6-30 分钟内 1. 31-60 分钟内 0. 60 分钟后

B2. 当您身处非吸烟区内，会不会感到难受而忍不住吸烟？ 1. 会 0. 不会

B3. 您觉得哪一支烟最难放弃？ 1. 早上第一支 0. 其它

B4. 您每天抽多少支烟？

0. 10支或以下 1. 11-20支 2. 21-30支 3. 31支或更多

B5. 当您生病几乎整天卧病在床时还会吸烟吗？ 1. 会 0. 不会

B6. 在起床后数小时内，您吸烟次数是否较在其他时间频繁？ 1. 会 0. 不会

0 To be completed by researcher: Total score: _____

Nicotine Dependency: 1. Mild (0-3) 2. Moderate (4-5) 3. Severe (6-10)

第二部分：戒烟史

- C7. 您过去一年曾试过几次戒烟24小时以上？
 0. 没有试过 (跳到D1) 1. 有，试过_____次（请在横线上填入具体数字）
- C8. 您最长多长时间没有吸烟？_____天（请在横线上填入具体数字）
- C9. 您最近一次尝试戒烟是什么时候？_____（请在横线上填入具体日期）
- C10. 您现在有没有打算戒烟？1. 有 0. 没有(Pre-contemplation) (跳去 D1)
- C11. 您打算从什么时候开始戒烟？(单选)
- 0. 我现在已经没有吸烟了 (action)
 - 1. 我会在近7天之内戒烟 (preparation/contemplation)
 - 2. 我会在近1个月之内戒烟 (preparation/contemplation)
 - 3. 我会在近6个月之内戒烟 (contemplation)
 - 4. 我会在6个月之后戒烟 (pre-contemplation)
 - 5. 还没做好决定 (pre-contemplation)
- C12. 1. 已决定的戒烟日期_____ 0. 未决定戒烟日期

确切时间：
 i) ___ 日后 或 ii) ___ 月后

0 Stage of readiness to quit smoking:

Action Preparation# Contemplation# Pre-contemplation

Preparation: At least one 24-hour quit attempt in the past year; **Contemplation:** No quit attempt

第三部分：家庭情况

- D1. 您目前共有几个孩子？_____ (请在横线上填入具体数字)
- D2. 和您同住的人之中，有多少人抽烟？_____人（请在横线上填入具体数字）；
 其中您的妻子是否抽烟？1. 现在有抽烟 2. 之前抽已经戒了 0. 从不抽烟

第四部分：自我效能

- E. 大多数吸烟人士在以下情况都会吸烟，请指出若在同样的情况下，你有多肯定能够在那些吸烟的诱惑下而不吸烟。

	1 绝对不肯定	2 不肯定	3 大概肯定	4 肯定	5 绝对肯定
1.觉得紧张	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.觉得忧郁不开心	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.愤怒时	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.觉得十分焦虑时	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.想思考难题的时候	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.当我有吸烟的渴望时	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.和朋友一起饮酒聊天时	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.在庆祝轰动的场合	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.引用啤酒、白酒，或其他含酒精饮料时	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.身边的人在吸烟	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.进餐后	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.喝咖啡或茶的时候	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

第五部分：健康状况

F1. 您是否饮酒：1. 是，饮酒量频率约是什么？ 0. 否（跳到F2）

0. <input type="checkbox"/> 偶尔喝一次	1. <input type="checkbox"/> 每月1-2次
2. <input type="checkbox"/> 每周1-2次	3. <input type="checkbox"/> 每天一次以上

F2. 您过一个月內有没有做过运动或者体育锻炼？1. 有 0. 没有（跳到F3）

您做的运动是什么？_____
您做运动的频率是多少？_____分钟/星期

F3. 总体来说，您认为您现时的健康状况是

5. 非常好 4. 很好 3. 好 2. 一般 1. 差

F4. 在过去一年，您有否患上一些长期疾病？（注：长期疾病是指某一疾病已影响您已有一段很长的时间或您因某一疾病而有一段很长的时间已受到困扰）

0. 有 没有（转至问题F6）

F5. 如有，您有否因这些疾病而限制了您的日常活动？

0. 有 没有

F6. 以下各项是您日常生活中可能进行的活动。以您目前的健康状况，您在进行这些活动时，有没有受到限制？如果有，程度如何？

F6-1. 中等强度的活动，例如搬桌子、打扫或清洁地板，打保龄球，或打太极拳？

0. 有很大限制 1. 有一点限制 2. 没有任何限制

F6-2. 是否影响你步行上楼？

0. 有很大限制 1. 有一点限制 2. 没有任何限制

F7. 在过去一个星期里，您会否因为身体健康的原因，在日常生活或工作中感到力不从心？

0. 会 1. 不会

F8. 在过去一个星期里的工作或日常活动中，您会否因为身体健康的原因而令您的工作或活动受到限制？

0. 会 1. 不会

F9. 在过去一个星期里，您会否因为情绪方面的原因（比如感到沮丧或焦虑）而令您在工作或日常活动中感到力不从心？

0. 会 1. 不会

F10. 在过去一个星期的工作或日常活动中，您会否因为情绪方面的原因（比如感到沮丧或者焦虑）而令您的工作或活动受到限制？

0. 会 1. 不会

F11. 在过去一个星期里，您身体上的疼痛对您的日常工作（包括上班和家务）有多大影响？

0. 完全没有影响 1. 有很少影响 2. 有一些影响
3. 有较大影响 4. 有非常大的影响 5. 不适用

F12. 以下问题是有关您在过去四个星期里自我感觉及其他的情况。针对每一个问题，请选择一个最接近您感觉的答案。

F12-1. 在过去一个星期里，您有多少时间感到心平气和？

1. 常常 2. 大部分时间 3. 很多时间
4. 一半一半 5. 只有很少时间 6. 从来没有

F12-2. 在过去一个星期里，您有多少时间感到精力充足？

1. 常常 2. 大部分时间 3. 很多时间
4. 一半一半 5. 偶尔一次半次 6. 从来没有

F12-3.在过去一个星期里，您有多少时间觉得心情不好、闷闷不乐或沮丧？

1. 常常 2. 大部分时间 3. 很多时间
4. 一半一半 5. 偶尔一次半次 6. 从来没有

F12-4.在过去一个星期里，有多少时间由于您身体健康或情绪问题而妨碍您的社交活动（比如探亲、访友等）？

1. 常常 2. 大部分时间 3. 很多时间
4. 一半一半 5. 偶尔一次半次 6. 从来没有

第六部分：戒烟辅导服务使用情况

G3. 请问过去一年到目前为止，有没有用过任何其他戒烟辅导服务？

1. 有 0. 没有（跳去第七部分）

G4. 您使用的是什么服务？（可多选）

- | | 没有 | 有 | （次数） |
|--------------------------------------|--------------------------|--------------------------|--------|
| 1. <input type="checkbox"/> 电话戒烟辅导 | <input type="checkbox"/> | <input type="checkbox"/> | （____） |
| 2. <input type="checkbox"/> 尼古丁替代治疗 | <input type="checkbox"/> | <input type="checkbox"/> | （____） |
| 3. <input type="checkbox"/> 面对面辅导 | <input type="checkbox"/> | <input type="checkbox"/> | （____） |
| 4. <input type="checkbox"/> 小组讨论戒烟辅导 | <input type="checkbox"/> | <input type="checkbox"/> | （____） |
| 5. <input type="checkbox"/> 戒烟药物治疗 | <input type="checkbox"/> | <input type="checkbox"/> | （____） |
| 6. <input type="checkbox"/> 针灸治疗 | <input type="checkbox"/> | <input type="checkbox"/> | （____） |
| 7. <input type="checkbox"/> 其他：_____ | <input type="checkbox"/> | <input type="checkbox"/> | （____） |

（请注明）

第七部分：基本资料

姓名：_____ 出生日期：_____年____月

微信（QQ）：_____ 联系电话：_____

联络偏好： 工作日 周末 均可

白天 晚上 特定时间：_____

H1. 您的最高教育程度是：

1. 小学(含)以下 2. 初中 3. 高中 4. 本科及以上

H2. 您现在的工作状态是：

1. 受雇 2. 自营 3. 无业

H3. 您的家庭人均年收入约为多少？

0. 1万以下 1. 1万-5万 2. 5万-10万 3. 10万-20万 4. 20万以上

—————多谢您的合作！问卷到此结束—————