Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

Health Care Use Questionnaire

You are being asked to voluntarily participate in a study. The purpose of this study is to understand health care use patterns and the risk of MRSA infections. The intended result of this study is to understand the risk factors for developing MRSA infections.

Individuals who have received some health care (i.e., doctor visit, dialysis, outpatient surgery) in the last 12 months can ***voluntarily participate*** in the study by completing this survey.

If you choose to participate in the study, please fill out the survey packet; it will take about 15 minutes. Please answer the questions by marking the response that best answers the question.

Minimal risks are involved. If you do not feel comfortable answering a certain question, then you do not need to answer the question. You may choose to withdraw from the study at any time.

Confidentiality of your answers will be maintained.

Instructions

- The survey takes about **15 minutes** to complete
- You can use either **a pen or a pencil** to mark your responses
- Your responses will remain **strictly confidential** and will not be shared with anyone outside the Indianapolis University-Purdue University-Indianapolis research team. Only the aggregate findings will be shared
- Questions appear on both sides of each sheet
- Please answer each question honestly. Although some questions may appear similar, every question has been selected carefully. There are no right or wrong answers

Please check the answer that best applies.	No	Yes	
In the last year, did anyone in your household have a MRSA infection?	No ☐	Yes ☐	
In the last year, did you share personal items (e.g. uniforms, clothes, razors, washcloths) that were used by a person infected with MRSA or a person with a history of MRSA infection?	No ☐	Yes ☐	
In the last year, did you have dialysis? (Dialysis is filtration of the blood to remove toxins and perform the work that the kidney normally does.)	No ☐	Yes ☐	**If you answered yes, how often did you have dialysis in the last year (check all that apply):** ☐ three times weekly ☐ daily, on a temporary basis ☐ other frequency Was the type of dialysis called hemodialysis (where blood is removed, filtered, and replaced)?: □ Yes □ No
In the last year, did you have any outpatient surgical procedures?	No ☐	Yes ☐	**If you answered yes, please provide month and year of each surgical procedure (mm/yyyy)** Dates: _____ Dates: _____ Dates: _____
In the last year, did you use intravenous (IV) medications at home?	No ☐	Yes ☐	**If you answered yes, please provide month and year of use (mm/yyyy) and types** Dates: _____ Drug: _____ Dates: _____ Drug: _____ Dates: _____ Drug: _____ Dates: _____ Drug: _____ Dates: _____ Drug: _____

In the last year, did you have an intravenous (IV) catheter, central venous line, or chemotherapy port in place while at home?	No ☐	Yes ☐	
In the past year, did you spend one or more nights in any of the following types of facilities:			
Acute Care Hospital	No ☐	Yes ☐	**If you answered yes, please provide dates of your stay(s) (mm/dd/yyyy to mm/dd/yyyy)** Dates: _____
Long Term Care Facility	No ☐	Yes ☐	**If you answered yes, please provide dates of your stay(s) (mm/dd/yyyy to mm/dd/yyyy)** Dates: _____
Nursing Home	No ☐	Yes ☐	**If you answered yes, please provide dates of your stay(s) (mm/dd/yyyy to mm/dd/yyyy)** Dates: _____
Skilled Nursing Facility	No ☐	Yes ☐	**If you answered yes, please provide dates of your stay(s) (mm/dd/yyyy to mm/dd/yyyy)** Dates: _____
Hospice	No ☐	Yes ☐	**If you answered yes, please provide dates of your stay(s) (mm/dd/yyyy to mm/dd/yyyy)** Dates: _____
In the past year, did you seek care at the Emergency Room?	No ☐	Yes ☐	**If you answered yes, please provide dates of your visit(s) (mm/dd/yyyy)** Dates: _____
In the past year, did you take any antibiotics (drugs for infections, such as Amoxicillin, Bactrim or Keflex)?	No ☐	Yes ☐	**If you answered yes, please provide medication and dates of use (mm/dd/yyyy to mm/dd/yyyy)** Med: _____ Dates: _____ Med: _____ Dates: _____

			Med: _____ Dates: _____ Med: _____ Dates: _____
In the past year, did you have any outpatient procedures? If yes, check all that apply: Endoscopy (a procedure to look at your stomach) Colonoscopy (a procedure to look in the colon for colorectal cancer) Interventional radiology procedure Add other, such as joint procedure, etc Specify_____	No ☐ ☐ ☐ ☐	Yes ☐ ☐ ☐ ☐	**If you answered yes, please give month and year of each outpatient procedure (mm/yyyy)** Date: _____ Date: _____ Date: _____ Date: _____
Have you ever had a MRSA infection?	No ☐	Yes ☐	**If yes, what type of infection was it?** **Skin?** **Blood?** **Other? _____ please specify.**

Please check or fill in the answer.	
In the past year, how many outpatient medical visits did you have?	☐ zero ☐ 1-2 ☐ 3-4 ☐ 5-8 ☐ 9-12 ☐ more than 13
In what year were you born?	|__|__|__|__| YYYY
What is your gender?	☐ Male ☐ Female
Are you Spanish/Hispanic/Latino?	☐ No ☐ Yes, Mexican, Mexican Am., Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino
What is your race? (MARK ONE OR MORE RACES)	☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
What is your zip code?	|__|__|__|__|__|
How many people live in your household (including yourself)?	|__|__|

THANK YOU for completing this survey. Please return to us in the stamped, self-addressed envelope provided with this survey.