

Attachment 9 -RE-SCREENER

ATLANTA, GA

TBD

() No

1. Name (First name Last initial): _____

2. City/Town of residence: _____

3. Age: _____

4. Are you:

[CHECK ONE]

() Married

() Never married

() Divorced or separated

() Widowed

() Living with a domestic partner

5. How many children under 18
are in your household? _____

6. What is the last grade of school or college you
had the opportunity to complete?

[CHECK ONE]

() Less than high school

() High school graduate/GED

() Some college

() 4-year college graduate

() Post-graduate degree

7. [WOMEN ONLY] Are you currently pregnant?

() Yes

The public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to - CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333 ATTN: PRA (0920-0919).

8. Are you:
[CHECK ALL THAT APPLY]
 Employed full-time
 Employed part-time
 Unemployed
 Retired
 Student

9. Occupation (if applicable): _____

10. Spouse/partner's occupation (if applicable):

11. How many focus groups have you ever attended? _____

12. What was the subject of those focus groups?

13. In the past 12 months, have you had any of the following medical conditions?

[MARK ONE RESPONSE IN EACH ROW]

		Yes	No
A	[WOMEN ONLY] Childbirth?	<input type="checkbox"/>	<input type="checkbox"/>
B	Fracture or broken bones?	<input type="checkbox"/>	<input type="checkbox"/>
C	Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
D	An injury or accident that required an overnight hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>
E	Cancer treatment?	<input type="checkbox"/>	<input type="checkbox"/>

14. In the past 12 months, have you had a hospital stay of 3 or more days?

() Yes

() No

15. Have you or a close family member ever had any of the following medical conditions?

[MARK ONE RESPONSE IN EACH ROW]

		Yes	No
A	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
B	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
C	Deep vein thrombosis, or DVT	<input type="checkbox"/>	<input type="checkbox"/>
D	Anemia	<input type="checkbox"/>	<input type="checkbox"/>

16. What magazines do you regularly read?

1. _____
2. _____
3. _____

17. What TV/radio shows do you regularly go to for your news?

1. _____
2. _____
3. _____

18. What newspapers/websites do you regularly read for your news?

1. _____
2. _____
3. _____

19. In the past year, have you looked for information about a health concern or medical problem?
- () Yes
- () No **[SKIP TO END]**

20. **[IF YES IN Q19]** Please indicate whether you tried to find health information in the past year from any of the following sources:

[MARK ONE RESPONSE IN EACH ROW]

		Yes	No
A.	Newspaper articles	<input type="checkbox"/>	<input type="checkbox"/>
B.	General interest magazines	<input type="checkbox"/>	<input type="checkbox"/>
C.	Health magazines	<input type="checkbox"/>	<input type="checkbox"/>
D.	Doctor or nurse	<input type="checkbox"/>	<input type="checkbox"/>
E.	Friends or relatives	<input type="checkbox"/>	<input type="checkbox"/>
F.	TV or radio	<input type="checkbox"/>	<input type="checkbox"/>
G.	Internet/World Wide Web	<input type="checkbox"/>	<input type="checkbox"/>

21. What websites have you visited for health information?

1. _____
2. _____
3. _____
- _____

PLEASE RETURN THIS QUESTIONNAIRE TO YOUR HOST OR HOSTESS.