**Attachment F: Community-associated *Clostridium difficile* Infection (CDI) Risk Factor Study Adult Case and Control Interview**

**Section 1: Identifiers- CASES and CONTROLS**

1. € CASE € CONTROL
2. Study ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Reference date: *\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_*

*(mm/dd/yyyy)*

2 week before *\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_*

4 weeks before *\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_*

12 weeks before *\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_*

4. Age (years) €€€

5. Sex € Male € Female

**Section 2: Illness Questions- \*\*\*\*\*\*\*CASES ONLY \*\*\*\*CONTROLS SKIP TO SECTION 3, Q. 10\*\*\*\*\*\*\*\*\*\***

**Now I will ask you questions about your illness.**

6. How many days did your diarrhea last? €€€

Don’t know/Not sure……..….7

Refused 9

6A. On the worst day of your diarrhea, what was the approximate number of stools you had in a 24-hour period?

≥3-<5 stools 1

5-10 stools 2

>10 stools 3

Don’t know/Not sure 7

Refused 9

7. Did you have any of the following symptoms associated with your *C. difficile* illness?

**[READ LIST]** Yes No DK/NS Refused

Bloody stools 1 2 7 9

Fever 1 2 7 9

Nausea 1 2 7 9

Vomiting 1 2 7 9

Abdominal pain 1 2 7 9

Other 1 2

Specify:\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Were you hospitalized overnight for your *C. difficile* illness?

Yes 1

8A. **If yes**, where: (*name of hospital will not be transmitted to CDC)*

No 2

Don’t know/Not sure 7

Refused 9

9. At the time of your *C. difficile* diagnosis, were you told by a doctor or healthcare provider that you had any other stomach [enteric, gastrointestinal] infection?

Yes 1

No 2 ***(Go to Q.10)***

Don’t know/Not sure 7 ***(Go to Q.10)***

Refused 9 ***(Go to Q.10)***

9A. ***If yes,*** what was the name of the infection?

**[Read list if necessary]** Yes No DK/NS Refused

*Campylobacter* 1 2 7 9

*E. coli* 1 2 7 9

*Listeria* 1 2 7 9

*Salmonella* 1 2 7 9

*Shigella* 1 2 7 9

*Vibrio* 1 2 7 9

*Yersinia* 1 2 7 9

*Cryptosporidium* 1 2 7 9

*Giardia* 1 2 7 9

*Rotavirus* 1 2 7 9

*Norovirus* 1 2 7 9

Other 1 2

Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: Healthcare contacts- Cases and Controls**

**Now I will ask you questions about your healthcare contacts between [12 weeks *before* Reference Date**\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**] to [Reference Date**\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**].**

10. Did you receive care in any doctor’s office, dental office, hospital, or any other medical facility in the 12 weeks *before* [REFERENCE DATE\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_]?

Yes 1

No 2 ***(Go to Q.11)***

Don’t know/Not sure 7 ***(Go to Q.11)***

Refused 9 ***(Go to Q.11)***

10A. I will now ask you about the types of places you visited for your healthcare and when you made your visit**.** Did you visit any of the following places?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***[READ LIST]*** | **YES=1** | **NO=2** | **DN/NS=7** | **Refuse=9** | **If yes, How many weeks prior to** (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ ) **did you visit this place?** | | |
|  |  |  |  |  | 2 weeks | 4 weeks | 12 weeks |
| Ambulatory / Outpatient procedure center |  |  |  |  |  |  |  |
| Ambulatory / Outpatient Surgery center |  |  |  |  |  |  |  |
| Dental office |  |  |  |  |  |  |  |
| Doctor’s office |  |  |  |  |  |  |  |
| ED |  |  |  |  |  |  |  |
| Hemodialysis |  |  |  |  |  |  |  |
| Hospital |  |  |  |  |  |  |  |
| Outpatient lab |  |  |  |  |  |  |  |
| Physical Therapy Center |  |  |  |  |  |  |  |
| Urgent Care |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

***IF NO TO ALL OPTIONS IN Q.10A then SKIP to Q.11***

10B. during those visits in the 12 weeks before (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)did you have any of the following procedures performed?

\*\*\*\*\*If Subject answered YES to dental visits only in 10A then only ask about last two items (oral surgery and dental cleaning)\*\*\*\*\*\*\*\*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***[READ LIST]*** | **YES=1** | **NO=2** | **DN/NS=7** | **Refuse=9** | **If yes, How many weeks prior to** (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_) **did this procedure happen?** | | |
|  |  |  |  |  | 2 weeks | 4 weeks | 12 weeks |
| Upper Endoscopy  (Did the doctors pass a tube through  your mouth or nose into your stomach?) |  |  |  |  |  |  |  |
| Colonoscopy or Sigmoidoscopy  (Did the doctors pass a tube into your  rectum to look into your colon/bowel?) |  |  |  |  |  |  |  |
| X-ray that required GI Prep  (Did you have an X-ray performed where  you had to swallow something first?) |  |  |  |  |  |  |  |
| Chemotherapy |  |  |  |  |  |  |  |
| Surgery in an operating room as an outpatient  **If yes, Specify type:** |  |  |  |  |  |  |  |
| Other Medical Procedure: |  |  |  |  |  |  |  |
| Oral Surgery |  |  |  |  |  |  |  |
| Dental Cleaning |  |  |  |  |  |  |  |

11. Did you visit a person in or accompany anyone to a doctor’s office, dental office, hospital, nursing home, or any other medical facility in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]?

Yes 1

No 2 ***(Go to Q.12)***

Don’t know/Not sure 7 ***(Go to Q.12)***

Refused 9 ***(Go to Q.12)***

11A. What type of facility did you visit or accompany someone to in the 12 weeks before [Reference Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***[READ LIST]*** | **YES=1** | **NO=2** | **DN/NS=7** | **Refuse=9** | **If yes, How many weeks prior to** (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_) **did you visit this place?** | | |
|  |  |  |  |  | 2 weeks | 4 weeks | 12 weeks |
| Ambulatory / Outpatient procedure center |  |  |  |  |  |  |  |
| Ambulatory / Outpatient Surgery center |  |  |  |  |  |  |  |
| Dental office |  |  |  |  |  |  |  |
| Doctor’s office |  |  |  |  |  |  |  |
| ED |  |  |  |  |  |  |  |
| Hemodialysis |  |  |  |  |  |  |  |
| Hospital |  |  |  |  |  |  |  |
| Long term care/ skilled nursing facility |  |  |  |  |  |  |  |
| Outpatient lab |  |  |  |  |  |  |  |
| Physical Therapy Center |  |  |  |  |  |  |  |
| Urgent Care |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

**Section 4: Household contacts**

**The next few questions are about you and persons who lived with you during the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_].**

12. How many people lived in your household including yourself during that time? € ***If answer is one (subject lives alone) skip to Q.19***

12A. How many household members, not including yourself were in each of these age groups? **[List number of people in each group]**

Ages €<1 €1 to 3 €4 to 10 €11 to 17 €18 to 34 €35 to 59 € 60+

13. Did any household member excluding yourself wear diapers? (Including adults in diapers)

Yes 1

No 2

Don’t know/Not sure 7

Refused 9

14. Did you have household members excluding yourself that attended a group childcare setting, daycare, or adult daycare? We consider daycare to be any place inside or outside your home where a household member spends at least 4 hours per week under an adult’s care with at least two adults or children who did not live with you

Yes 1

No 2 (**Skip to Q 15)**

Don’t know/Not sure 7 (**Skip to Q 15)**

Refused 9 (**Skip to Q 15)**

14A. ***If yes,*** which household members attended daycare and what type of daycare setting was it? **[*Read description of setting types if necessary*]**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AGE Group** | **Type of Daycare Setting** | | | | | |
|  | **Home** | **Center** | **Nanny** | **Other (specify)** | **Don’t know** | **Refused** |
| < 1 | 1 | 2 | 3 |  | 7 | 9 |
| 1 to 3 | 1 | 2 | 3 |  | 7 | 9 |
| 4 to 10 | 1 | 2 | 3 |  | 7 | 9 |
| 11 to 17 | 1 | 2 | 3 |  | 7 | 9 |
| 18 to 34 | 1 | 2 | 3 |  | 7 | 9 |
| 35 to 59 | 1 | 2 | 3 |  | 7 | 9 |
| 60 + | 1 | 2 | 3 |  | 7 | 9 |

**Home** – care is provided in someone’s home typically by one person

**Cente**r- care is provided typically in a commercial building with many providers and rooms

**Nanny / care provider share**- two or more families have a single nanny / care provider to take care of their household member either full-time or part-time

15. In the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)], did any household member stay overnight in a hospital?

Yes 1

No 2

Don’t know/Not sure 7

Refused 9

16. In the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)], did any household member stay overnight in a nursing home?

Yes 1

No 2

Don’t know/Not sure 7

Refused 9

17. In the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)], did anyone else in your household have diarrhea?

Yes 1

No 2 ***(Go to Q.18)***

Don’t know/Not sure 7 ***(Go to Q.18)***

Refused 9 ***(Go to Q.18)***

17A. ***If yes,*** did you assist this person with toileting (including diaper changes)?

Yes 1

No 2

Don’t know/Not sure 7

Refused 9

17B. Was this person diagnosed with *C. difficile?*

Yes 1

No 2

Don’t know/Not sure 7

Refused 9

18. Did any of your household members work or volunteer, in any capacity, at a hospital, other medical facility, or in any facility where patient care is provided in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)]?

Yes 1

No 2 ***(Go to Q.19)***

Don’t know/Not sure 7 ***(Go to Q.19)***

Refused 9 ***(Go to Q.19)***

18A. ***If yes,*** what type of healthcare setting?

**(READ LIST)** Yes No DK/NS Refused

Hospital 1 2 7 9

Emergency department 1 2 7 9

Doctor’s office 1 2 7 9

Dentist 1 2 7 9

Long term care (skilled nursing facility) 1 2 7 9

Hemodialysis facility 1 2 7 9

Other facility 1 2

Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18B. Did their job involve direct physical contact with the patients? For example, touching the patient to help her get out of a chair

Yes 1

No 2 ***(Go to Q.19)***

Don’t know/Not sure 7 ***(Go to Q.19)***

Refused 9 ***(Go to Q.19)***

18B1. ***If yes,***what was their main job?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18B2. Job Code€€-€€€€ ***(Fill in job code after interview is finished)***

19. Did you work or volunteer, in any capacity, at a hospital, other medical facility, or in any facility where patient care is provided in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)]?

Yes 1

No 2 ***(Go to Q.20)***

Don’t know/Not sure 7 ***(Go to Q.20)***

Refused 9 ***(Go to Q.20)***

19A. ***If yes,*** what type of healthcare setting?

**(READ LIST)** Yes No DK/NS Refused

Hospital 1 2 7 9

Emergency department 1 2 7 9

Doctor’s office 1 2 7 9

Dentist 1 2 7 9

Long term care (skilled nursing facility) 1 2 7 9

Hemodialysis facility 1 2 7 9

Other facility 1 2

Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19B. Did your job involve direct physical contact with the patients? For example, touching the patient to help her get out of a chair

Yes 1

No 2 ***(Go to Q.20)***

Don’t know/Not sure 7 ***(Go to Q.20)***

Refused 9 ***(Go to Q.20)***

19B1. ***If yes,***what was your main job?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19B2. Job Code€€-€€€€ ***(Fill in job code after interview is finished)***

20**.** Did you attend an adult daycare in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)]? We consider daycare to be any place inside or outside your home where a household member spends at least 4 hours per week under an adult’s care with at least two adults who do not live with you

Yes 1

No 2 (**Skip to Q.21)**

Don’t know/Not sure 7 (**Skip to Q.21)**

Refused 9 (**Skip to Q.21)**

20A. ***If yes,*** what type of care setting? **[Read list if necessary]**

Home – care is provided in someone’s home typically by one person 1

Center- care is provided typically in a commercial building with many providers and rooms 2

Nanny / care provider share- two or more families have a single nanny / care provider to take care of their household member either full-time or part-time 3

Other 4

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Don’t know/Not sure 7

Refused 9

**Section 5: Diet Exposures**

**I’d like to change direction now and ask you about the foods you generally eat in a given week and the kind of water you drink.**

21. Did you receive food / formula through a feeding tube called a G-tube or J-tube in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_)]?

Yes 1

No 2

Don’t know/Not sure 7

Refused 9

22. In a typical week how frequently do you consume the following foods?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **[READ LIST]** | Often | Sometimes | Rarely | Never | DK/NS | Refused |
|  | **>5/week** | **2-5 /week** | **<2/ week** | **Never** |  |  |
| Eggs | 1 | 2 | 4 | 5 | 7 | 9 |
| Dairy (milk, yogurt) | 1 | 2 | 4 | 5 | 7 | 9 |
| Fresh raw Vegetables | 1 | 2 | 4 | 5 | 7 | 9 |
| Plant based protein (tofu, tempeh, seitan) | 1 | 2 | 4 | 5 | 7 | 9 |
| Red Meat (beef, lamb, pork, other game meat) | 1 | 2 | 4 | 5 | 7 | 9 |
| Poultry (chicken, turkey) | 1 | 2 | 4 | 5 | 7 | 9 |
| Seafood (fish, shellfish) | 1 | 2 | 4 | 5 | 7 | 9 |

23. Which one of the following is the source of tap water in your home (select only one):

□ water utility □ private well □ spring □ unknown □ other

Name of the water utility, if known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If other, specify type and location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23A. At home, what type of unboiled water do you most often use for drinking (chose only one)?

\_\_\_\_\_\_ Tap water not treated in the home

\_\_\_\_\_\_ Tap water treated in the home (for example, filtered, UV light, distilled, or whole house point-of-entry device)

\_\_\_\_\_\_Commercially bottled water

\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6: Medical History**

**The next sets of questions are about medications you may have been taking in the 12 weeks before [Reference Date**\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**]. Medicine bottles or records may help you remember about specific medications. Would you like to gather this information before we go on?**

24. Did you take any antibiotics by mouth or in your vein in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]?

Yes 1

No 2 ***(Go to Q.28)***

Don’t know/Not sure 7 ***(Go to Q.28)***

Refused 9 ***(Go to Q.28)***

24A. Why did you take these antibiotic(s)?

***Note: Subjects may indicate more than one reason (For example, if more than one course of antibiotics was taken for different illnesses or if one antibiotic was taken for and ear infection and a pneumonia)***

|  |  |  |
| --- | --- | --- |
| **[DO NOT READ LIST]** | Yes | No |
| Acne | 1 | 2 |
| Bronchitis/ pneumonia | 1 | 2 |
| Dental cleaning | 1 | 2 |
|  |  |  |
| Ear, sinus, upper respiratory infection | 1 | 2 |
| Eye infection | 1 | 2 |
| Oral surgery | 1 | 2 |
|  |  |  |
| Skin or soft tissue infection(abscess or cellulitis) | 1 | 2 |
| Surgery | 1 | 2 |
| Urinary tract infection | 1 | 2 |
| Urinary tract prophylaxis | 1 | 2 |
| Refused | 9 | 9 |
| DK/NS | 7 | 7 |
| Other | 1 | 2 |
| Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

24B. Which antibiotic(s) did you take in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]? **[DO NOT READ LIST]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **[DO NOT READ LIST]** |  | ***If yes,*** *How many weeks prior to (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_) did you take this antibiotic?* | | |
|  | YES | **2-weeks** | **4-weeks** | **12-weeks** |
| Amoxicillin | 1 |  |  |  |
| Amoxicillin/Clavulanate | 1 |  |  |  |
| Ampicillin | 1 |  |  |  |
| Augmentin | 1 |  |  |  |
| Azithromycin | 1 |  |  |  |
| Bactrim | 1 |  |  |  |
| Biaxin | 1 |  |  |  |
| Ceclor | 1 |  |  |  |
| Cefaclor | 1 |  |  |  |
| Cefadroxil | 1 |  |  |  |
| Cefdinir | 1 |  |  |  |
| Ceftin | 1 |  |  |  |
| Cefixime | 1 |  |  |  |
| Cefuorixime | 1 |  |  |  |
| Cefzil | 1 |  |  |  |
|  |  | ***If yes,*** *How many weeks prior to (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_) did you take this antibiotic?* | | |
| **[DO NOT READ LIST]** |  | **2-weeks** | **4-weeks** | **12-weeks** |
| Cephradine | 1 |  |  |  |
| Ciprofloxacin or Cipro | 1 |  |  |  |
| Clarithromyc | 1 |  |  |  |
| Cleocin | 1 |  |  |  |
| Clindamycin | 1 |  |  |  |
| Dapsone | 1 |  |  |  |
| Doxycycline | 1 |  |  |  |
| Duricef | 1 |  |  |  |
| Erythromycin | 1 |  |  |  |
| Erythromycin/sulfa | 1 |  |  |  |
| Flagyl | 1 |  |  |  |
| Floxin | 1 |  |  |  |
| Keflex | 1 |  |  |  |
| Keftab | 1 |  |  |  |
| Levofloxacin | 1 |  |  |  |
| Levoquin | 1 |  |  |  |
| Monurol | 1 |  |  |  |
| Metronidazole | 1 |  |  |  |
| Norfloxacin or Norflox | 1 |  |  |  |
| Ofloxacin or Oflox | 1 |  |  |  |
| Omnicef | 1 |  |  |  |
| Penicillin or Pen VK | 1 |  |  |  |
| Pediazole | 1 |  |  |  |
| Septra | 1 |  |  |  |
| Suprax | 1 |  |  |  |
| Tetracycline | 1 |  |  |  |
| Trimox | 1 |  |  |  |
| Trimethoprim/Sulfa | 1 |  |  |  |
| Vancomycin | 1 |  |  |  |
| Zithromax or Z-Pak | 1 |  |  |  |
| Clindamycin | 1 |  |  |  |
| Other antibiotic 1 | 1 |  |  |  |
| Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1 |  |  |  |
| Other antibiotic 2 | 1 |  |  |  |
| Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1 |  |  |  |
| Don’t know/Not sure | 7 |  |  |  |
| Refused | 9 |  |  |  |

25. Did you use any antibiotic eye drops in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]?

Yes 1

No 2 ***(Go to Q.26)***

Don’t know/Not sure 7 ***(Go to Q.26)***

Refused 9 ***(Go to Q.26)***

25 A. ***If yes,*** what was the name of the drop (**read list if necessary**)?

Polytrim (Polymyxin sulfate / TMP)…….1

Ciloxan (Ciprofloxacin)…………………..2

Ocuflox (Ofloxacin)……………………….3

Vigamox, Moxeza (Moxifloxacin) ……..4

Other……………………………………….9

Specify :

26. In the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_], did you regularly take any acid-reducing medications to treat excessive stomach acid, heartburn, or gastroesophageal reflux disease (GERD)? We define regular use as use of the product at least 3 days per week. Such medications might include Tums, Prevacid, Maalox, Mylanta, Tagamet, Zantac, Prilosec, or Nexium.

Yes 1

No 2 ***(Go to Q.27)***

Don’t know/Not sure 7 ***(Go to Q.27)***

Refused 9 ***(Go to Q.27)***

26A. ***If Yes*,** please specify which medicine you regularly took in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***[DO NOT READ LIST]*** | **YES=1** | **NO=2** | **If yes, How many weeks prior to** (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ ) **did you take this medication?** | | |
|  |  |  | 2 weeks | 4 weeks | 12 weeks |
| Aciphex/rabeprazole | 1 | 2 |  |  |  |
| Alka-Seltzer | 1 | 2 |  |  |  |
| Maalox | 1 | 2 |  |  |  |
| Mylanta | 1 | 2 |  |  |  |
| Nexium/esomeprazole | 1 | 2 |  |  |  |
| Pepcid/famotidine | 1 | 2 |  |  |  |
| Prevacid/lansoprazole | 1 | 2 |  |  |  |
| Prilosec/omeprazole | 1 | 2 |  |  |  |
| Protonix/pantoprazole | 1 | 2 |  |  |  |
| Rolaids | 1 | 2 |  |  |  |
| Tums | 1 | 2 |  |  |  |
| Tagamet/cimetidine | 1 | 2 |  |  |  |
| Zantac/ranitidine | 1 | 2 |  |  |  |
| Other: | 1 | 2 |  |  |  |
| Don’t Know/not sure | 7 | 7 |  |  |  |
| Refuse | 9 | 9 |  |  |  |

***If yes****,* in the

2 weeks before

**I am now going to ask about medications that are given for many reasons including things like chronic pain, depression, anxiety, to stop smoking, and to help sleep. We are asking about these medications to determine if they could put people at risk for *C. diff*. Examples of these medications include: Prozac, Celexa, Remeron, Paxil, and Trazadone.**

27. In the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_], did you regularly take any such medications? We define regular use as use of the product at least 3 days per week.

Yes 1

No 2 ***(Go to Q.28)***

Don’t know/Not sure 7 ***(Go to Q.28)***

Refused 9 ***(Go to Q.28)***

27A. ***If Yes,*** *please specify which medicine you regularly took in the 12 weeks before [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***[DO NOT READ LIST]*** |  | | **If yes, How many weeks prior to** (Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ ) **did you take this medication?** | | |
|  | **YES** | **NO** | 2 weeks | 4 weeks | 12 weeks |
| Amitriptyline | 1 | 2 |  |  |  |
| Anafranil (Clomipramine) | 1 | 2 |  |  |  |
| Asendin (Amoxapine) | 1 | 2 |  |  |  |
| Celexa, Cipramil (Citalopram) | 1 | 2 |  |  |  |
| Cymbalta (Duloxetine) | 1 | 2 |  |  |  |
| Effexor (Venlafaxine) | 1 | 2 |  |  |  |
| Eldepryl, Emsam, Zelapar (Selegiline) | 1 | 2 |  |  |  |
| Escitalopram | 1 | 2 |  |  |  |
| Limbitrol (Chlordiazepoxide/Amitriptyline) | 1 | 2 |  |  |  |
| Ludiomil,(Maprotiline) | 1 | 2 |  |  |  |
| Luvox (Fluvoxamine) | 1 | 2 |  |  |  |
| Marplan, (Isocarboxazid) | 1 | 2 |  |  |  |
| Nardil, Nardelzine (Phenelzine sulfate) | 1 | 2 |  |  |  |
| Norpramin (Desipramine) | 1 | 2 |  |  |  |
| Nortriptyline | 1 | 2 |  |  |  |
| Parnate,(Tranylcypromine) | 1 | 2 |  |  |  |
| Paxil (Paroxetine) | 1 | 2 |  |  |  |
| Pristiq (Desvenlafaxine) | 1 | 2 |  |  |  |
| Prozac, Sarafem, Fontex  (Fluoxetine) | 1 | 2 |  |  |  |
| Remeron, Avanza, Zispin (Mirtazapine) | 1 | 2 |  |  |  |
| Savella, (Milnacipran) | 1 | 2 |  |  |  |
| Serzone, (Nefazodone) | 1 | 2 |  |  |  |
| Silenor, Prudoxin, Zonalon (Doxepin) | 1 | 2 |  |  |  |
| Surmontil (Trimipramine) | 1 | 2 |  |  |  |
| Symbyax (Olanzapine/fluoxetine) | 1 | 2 |  |  |  |
| Tofranil, (Imipramine) | 1 | 2 |  |  |  |
| Trazadone | 1 | 2 |  |  |  |
| Triptafen (amitriptyline/perphenazine) | 1 | 2 |  |  |  |
| Viibryd (Vilazodone) | 1 | 2 |  |  |  |
| Vivactil, (Protriptyline) | 1 | 2 |  |  |  |
| Wellbutrin, Zyban (Bupropion) | 1 | 2 |  |  |  |
| Zoloft, Lustral (Sertraline) | 1 | 2 |  |  |  |
| Other:  Specify: | 1 | 2 |  |  |  |
| Don’t know/Not Sure | 7 | 7 |  |  |  |
| Refuse | 9 | 9 |  |  |  |

***If yes****,* in the

2 weeks before

**Now I am going to ask you about medical conditions you may have had.**

28. **Prior to** [Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_], were you ever told by a medical provider that you had any of the following medical conditions?

**[READ LIST – including information in parentheses]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **READ LIST** | **Yes** | **No** | **DK/NS** | **Refused** |
| Diabetes |  |  |  |  |
| Heart attack |  |  |  |  |
| Congestive heart failure |  |  |  |  |
| Stroke |  |  |  |  |
| High blood pressure |  |  |  |  |
| Peripheral vascular disease  (intermittent claudication, gangrene, peripheral arterial bypass) arterial bypass) |  |  |  |  |
| Chronic renal (kidney) failure |  |  |  |  |
| **If yes,** are you on dialysis or awaiting dialysis? |  |  |  |  |
| Chronic lung disease (COPD, emphysema) |  |  |  |  |
| Asthma |  |  |  |  |
| Cystic fibrosis |  |  |  |  |
| Chronic Hepatitis B infection |  |  |  |  |
| Chronic Hepatitis C infection |  |  |  |  |
| Organ transplant |  |  |  |  |
| Bone marrow transplant |  |  |  |  |
| Leukemia or lymphoma |  |  |  |  |
| Sickle cell disease (not sickle cell trait) |  |  |  |  |
| Solid tumor cancer (e.g. bone, liver, brain) |  |  |  |  |
| Short gut disease (bowel/ intestinal insufficiency |  |  |  |  |
| Inflammatory bowel disease (Crohn’s disease, Ulcerative colitis) |  |  |  |  |
| Lupus |  |  |  |  |
| Rheumatoid arthritis |  |  |  |  |
| Depression |  |  |  |  |
| Other illness: |  |  |  |  |
|  |  |  |  |  |

29. There is some evidence that how much you weight may effect infection with *C. difficile*. What is your height and Weight?

Height: Ft in or \_\_\_\_\_\_cm

Weight: lbs or \_\_\_\_\_\_\_\_ Kg

Don’t Know/ Not Sure….7

Refused ………………..9

**Section 8: Demographics**

***Now I would like to ask you a few final questions.***

30. Do you consider yourself to be? **[Read responses 1 & 2]**

(    ) 1 Hispanic or Latino

(    ) 2 Not Hispanic or Latino

(    ) 7 Don’t Know/Not Sure (DO NOT READ)

(    ) 9 Refused (DO NOT READ)

( ) 10. Other racial category (DO NOT READ)

31.I am going to read a list of racial categories. Which one or more of the following do you consider yourself to be…? **[Read responses 1-5 and allow respondent to select one or more]**

(   ) 1 White/Caucasian

(   ) 2 Black or African-American

(   ) 3 American Indian or Alaska Native

(   ) 4 Native Hawaiian or Other Pacific Islander

(   ) 5 Asian

(   ) 7 Don’t Know/Not Sure (DO NOT READ)

(   ) 9 Refused (DO NOT READ)

( ) 10. Other racial category (DO NOT READ)

32. What is your occupation?

33. What was your main type of health care coverage during (12 weeks before Reference Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ ) ***I’m going to read all the choices***.

Private insurance, such as an HMO, PPO or a managed care plan 1

Public insurance, such as Medicaid, Medicare or state assistance program 2

A combination of private and public insurance 3

No health insurance 4

DO NOT READ: Other [specify] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8

Don’t know or not sure 7

Refused 9

**Because education and income can affect access to healthcare, I’d like to ask you about a couple of questions on these subjects.**

34 What is the highest grade or year of school you completed?

|  |
| --- |
| \_\_\_1 Never attended school or kindergarten only |
| \_\_\_2 Elementary or middle school; 1st-8th grade |
| \_\_\_3 Some high school; 9th-11th grade |
| \_\_\_4 High school graduate; 12th grade or GED |
| \_\_\_5 College or technical school for 1-3 years |
| \_\_\_6 College for 4 years, with or without a degree |
| \_\_\_9 Refused |

35 In your home, what is the annual gross household income from all sources, including social security and pensions? ***Read each response in order until respondent agrees***.

|  |  |
| --- | --- |
| \_\_\_0 Dependent college student | |
| \_\_\_1 Less than $15,000 | \_\_\_5 Less than $70,000 |
| \_\_\_2 Less than $25,000 | \_\_\_6 $70,000 or more |
| \_\_\_3 Less than $35,000 | \_\_\_7 Don’t know or not sure |
| \_\_\_4 Less than $50,000 | \_\_\_9 Refused |

**That was my last interview question. Thank you very much for your time and participation!**

36. Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

37. Interview Completed? € Yes  € No

38. Date of interview: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

*(mm/dd/yyyy)*

39. Interviewer initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Interview Appendix—Job Codes**

**OFFICE OF MANAGEMENT AND BUDGET - 1998 Standard Occupational Classification**

29-0000 Healthcare Practitioners and Technical Occupations

29-1000 Health Diagnosing and Treating Practitioners

29-1010 Chiropractors

29-1020 Dentists

29-1021 Dentists, General

29-1022 Oral and Maxillofacial Surgeons

29-1023 Orthodontists

29-1024 Prosthodontists

29-1029 Dentists, All Other Specialists

29-1030 Dietitians and Nutritionists

29-1040 Optometrists

29-1050 Pharmacists

29-1060 Physicians and Surgeons

29-1061 Anesthesiologists

29-1062 Family and General Practitioners

29-1063 Internists, General

29-1064 Obstetricians and Gynecologists

29-1065 Pediatricians, General

29-1066 Psychiatrists

29-1067 Surgeons

29-1069 Physicians and Surgeons, All Other

29-1070 Physician Assistants

29-1080 Podiatrists

29-1110 Registered Nurses

29-1120 Therapists

29-1121 Audiologists

29-1122 Occupational Therapists

29-1123 Physical Therapists

29-1124 Radiation Therapists

29-1125 Recreational Therapists

29-1126 Respiratory Therapists

29-1127 Speech-Language Pathologists

29-1129 Therapists, All Other

29-1130 Veterinarians

29-1190 Miscellaneous Health Diagnosing and Treating Practitioners

29-1199 Health Diagnosing and Treating Practitioners, All Other

29-2000 Health Technologists and Technicians

29-2010 Clinical Laboratory Technologists and Technicians

29-2011 Medical and Clinical Laboratory Technologists

29-2012 Medical and Clinical Laboratory Technicians

29-2020 Dental Hygienists

29-2030 Diagnostic Related Technologists and Technicians

29-2031 Cardiovascular Technologists and Technicians

29-2032 Diagnostic Medical Sonographers

29-2033 Nuclear Medicine Technologists

29-2034 Radiologic Technologists and Technicians

29-2040 Emergency Medical Technicians and Paramedics

29-2050 Health Diagnosing and Treating Practitioner Support Technicians

29-2051 Dietetic Technicians

29-2052 Pharmacy Technicians

29-2053 Psychiatric Technicians

29-2054 Respiratory Therapy Technicians

29-2055 Surgical Technologists

29-2056 Veterinary Technologists and Technicians

29-2060 Licensed Practical and Licensed Vocational Nurses

29-2070 Medical Records and Health Information Technicians

29-2080 Opticians, Dispensing

29-2090 Miscellaneous Health Technologists and Technicians

29-2091 Orthotists and Prosthetists

29-2099 Health Technologists and Technicians, All Other

29-9000 Other Healthcare Practitioners and Technical Occupations

29-9010 Occupational Health and Safety Specialists and Technicians

29-9011 Occupational Health and Safety Specialists

29-9012 Occupational Health and Safety Technicians

29-9090 Miscellaneous Health Practitioners and Technical Workers

29-9091 Athletic Trainers

29-9099 Healthcare Practitioners and Technical Workers, All Other

31-0000 Healthcare Support Occupations

31-1000 Nursing, Psychiatric, and Home Health Aides

31-1010 Nursing, Psychiatric, and Home Health Aides

31-1011 Home Health Aides

31-1012 Nursing Aides, Orderlies, and Attendants

31-1013 Psychiatric Aides

31-2000 Occupational and Physical Therapist Assistants and Aides

31-2010 Occupational Therapist Assistants and Aides

31-2011 Occupational Therapist Assistants

31-2012 Occupational Therapist Aides

31-2020 Physical Therapist Assistants and Aides

31-2021 Physical Therapist Assistants

31-2022 Physical Therapist Aides

31-9000 Other Healthcare Support Occupations

31-9010 Massage Therapists

31-9090 Miscellaneous Healthcare Support Occupations

31-9091 Dental Assistants

31-9092 Medical Assistants

31-9093 Medical Equipment Preparers

31-9094 Medical Transcriptionists

31-9095 Pharmacy Aides

31-9096 Veterinary Assistants and Laboratory Animal Caretakers

31-9099 Healthcare Support Workers, All Other