€ CASE € CONTROL

Form Approved OMB No. Exp. Date

Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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********

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____
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
No.....2
Don't know/Not sure.....7
Refused.....9

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

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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?

€ CASE € CONTROL
Patient ID:_____
State ID:_____

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							
Outpatient lab							
Physical Therapy Center							
Urgent Care							
Other							

IF NO TO ALL

OPTIONS IN Q.10A then SKIP to Q.11

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____
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:							

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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____/_____/_____]?

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

SECTION 4:

[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							

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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

Center- 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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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.

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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 <u>one</u> 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)***

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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			

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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			

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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_____/_____/_____]*

€ CASE € CONTROL

Patient ID:_____

State ID:_ ***[DO NOT READ LIST]***_

REFERENCE Date _____/_____/_____

			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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

2 weeks before

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____
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)				
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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

___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:
_____

_____
_____

_____
_____

_____
_____

_____
_____

37. Interview Completed? € Yes € No

38. Date of interview: ____/____/_____
(mm/dd/yyyy)

39. Interviewer initials: _____

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

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