€ CASE € CONTROL

Form Approved OMB No. Exp. Date

Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

Attachment G: Community-associated *Clostridium difficile* Infection (CDI) Risk Factor Study Pediatric 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 _____Months

5. Sex € Male € Female

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

REFERENCE Date _____/_____/_____

SECTION 2: ILLNESS QUESTIONS- *******CASES ONLY ****CONTROLS SKIP TO SECTION 3, Q. 10********

Now I will ask you questions about your child's illness.

6. How many days did your child's diarrhea last? €€€

Don't know/Not sure.....7
Refused.....9

6A.On the worst day of your child's diarrhea, what was the approximate number of stools your child 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 your child have any of the following symptoms associated with [his/ her] *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. Was your child hospitalized overnight for [his/ her] *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 child's *C. difficile* diagnosis, was your child told by a doctor or healthcare provider that [she/ he] 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 child's healthcare contacts between [12 weeks *before* Reference Date_____/_____/_____] to [Reference Date_____/_____/_____].

10. Did your child 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 your child visited for [his / her] healthcare in that time period and when [he / she] made the visit**.** Did your child 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**	**How many weeks prior to** (Reference Date_____/_____/_____) **did your child 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 your child 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**	**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 →**If yes, Specify type:**							
Other Medical Procedure:							
Oral Surgery							

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

REFERENCE Date _____/_____/_____

Dental Cleaning							

11. Did your child 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 your child visit or accompany someone to in the 12 weeks before [REFERENCE DATE ____/_____/_____]?

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

REFERENCE Date _____/_____/_____

[READ LIST]	YES=1	NO=2	DN/NS=7	Refuse=9	**How many weeks prior to** (Reference Date_____/_____/_____) **did your child 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 your child and persons who lived with your child during the 12 weeks before [Reference Date_____/_____/_____].

12. Excluding your child, how many people lived in your child's household during that time? €

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

Ages € <1 € 1 to 3 € 4 to 10 € 11 to 18 € 19 to 34 € 35 to 59 € 60+

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

Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

14. Did any household members excluding your child attend 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 other people who do not live with your child.

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

REFERENCE Date _____/_____/_____

Yes.....1
No.....2 (**Go to Q.15)**
Don't know/Not sure.....7 (**Go to Q.15)**
Refused.....9 (**Go 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

17. In the 12 weeks before [Reference Date_____/_____/_____)], did anyone else in your child's household have diarrhea?

Yes.....1
No.....2 ***(Go to Q.19)***
Don't know/Not sure.....7 ***(Go to Q.19)***

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

REFERENCE Date _____/_____/_____

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

18A. ***If yes,*** did your child assist this person with toileting (including diaper changes)?
Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

18B. Was this person diagnosed with *C. difficile?*
Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

19. Did any of your child's household members work at 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 their job involve direct physical contact with 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)***

19C. ***If yes,*** what was their main job?

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

REFERENCE Date _____/_____/_____

_____

_____

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

20**.** Did your child attend a group childcare or daycare in the 12 weeks before [Reference Date_____/_____/_____)] ? We consider daycare to be any place inside or outside your home where your child spends at least 4 hours per week under an adult's care with at least two children who do not live with you

Yes.....1
No.....2 (**Go to Q.16)**
Don't know/Not sure.....7 (**Go to Q.16)**
Refused.....9 (**Go to Q.16)**

20A. ***If yes,*** what type of childcare 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 your child generally eats in a given week and the kind of water your child drinks.

21. Did your child 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 does your child 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-cut raw Vegetables	1	2	4	5	7	9
Plant based protein (tofu, tempeh, seitan)	1	2	4	5	7	9
Red Meat (beef, lamb, other game meat)	1	2	4	5	7	9

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

REFERENCE Date _____/_____/_____

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 child's 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 does your child 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 _____

24. During the first 6-months of your child's life, would you say: (*read choices*)

Almost 100% of feedings were breast milk with no or very little formula……1

Most feedings (about 75%) were breast milk and the rest were formula…….2

About half (or 50%) of feedings were breast milk and half were formula…..3

Most feedings (about 75%) were formula and the rest were breast milk…….4

Almost 100% of feedings were formula with no or very little breast milk……..5

Don't know/Not sure.....7
Refused.....9

<u>SECTION 6: MEDICAL HISTORY</u>

The next set of questions are about medications your child 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?

25. Did your child take any antibiotics by mouth or in [his / her] vein in the 12 weeks before [Reference Date____/____/_____]?

Yes.....1
No.....2 ***(Go to Q.27)***
Don't know/Not sure.....7 ***(Go to Q.27)***
Refused.....9 ***(Go to Q.27)***

26. Why did your child take these antibiotics?

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)

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

REFERENCE Date _____/_____/_____

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

26A. Which antibiotic(s) did your child take in the 12 weeks before [Reference Date_____/_____/_____]?
[DO NOT READ LIST]

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

REFERENCE Date _____/_____/_____

		If yes, *How many weeks prior to (Reference Date_____/_____/_____) did your child take this antibiotic*		
[DO NOT READ LIST]		**2-weeks**	**4-weeks**	**12-weeks**
	Yes	Yes	Yes	Yes
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			
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			
Q. 26A CONTINUED		***If yes,*** *How many weeks prior to (Reference Date_____/_____/_____) did your child take this*		

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

REFERENCE Date _____/_____/_____

		antibiotic		
[DO NOT READ LIST]		**2-weeks**	**4-weeks**	**12-weeks**
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			

27. Did your child use any antibiotic eye drops 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)***

27 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 : .....

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

REFERENCE Date _____/_____/_____

28. In the 12 weeks before [Reference Date_____/_____/_____], did your child 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 Prevacid, Tums, Maalox, Mylanta, Tagamet, Zantac, Prilosec, or Nexium.

Yes.....1
No.....2 ***(Go to Q.29)***
Don't know/Not sure.....7 ***(Go to Q.29)***
Refused.....9 ***(Go to Q.29)***

28A. ***If Yes*****,** please specify which medicine your child regularly took in those 12 weeks.

[DO NOT READ LIST]	**YES= 1**	**NO=2**	**How many weeks prior to** (Reference Date_____/_____/_____) **did your child 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, 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.

29. In the 12 weeks before [Reference Date_____/_____/_____], did your child regularly take any such medications? We define regular use as use of the product at least 3 days per week.

€ CASE € CONTROL

Patient ID:_____

State ID:_____

~~*[DO NOT READ LIST]*~~

REFERENCE Date _____/_____/_____

			How many weeks prior to (Reference Date_____/_____/_____) **did your child 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:		17			
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 your child may have had.

30. **Prior to** [Reference Date_____/_____/_____], were you ever told by a medical provider that your child had any of the following medical conditions? **[READ LIST – including information in parentheses]**

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

REFERENCE Date _____/_____/_____

READ LIST	Yes	No	DK/NS	Refused
Congenital heart disease Specify:				
Diabetes				
Chronic renal (kidney) failure				
⟶**If yes,** is your child on dialysis or awaiting dialysis?				
Chronic lung disease (BPD)				
Asthma				
Cystic fibrosis				
Organ transplant				
Bone marrow transplant				
Leukemia or lymphoma				
Sickle cell disease (not sickle cell trait)				
Cancer (e.g. bone, liver, brain)				
Short gut disease (bowel/ intestinal insufficiency)				
Depression				
Born by C-section?				
Stay in the NICU at birth?				
⟶ **If yes,** was your child premature? ⟶ How many weeks premature?_____				
⟶**If yes,** how many weeks in the NICU?				
Other illnesses:				

31. There is some evidence that how much you weigh may effect infection with *C. difficile*. What are your child's most recent height or length and weight?

Don't know/ Not Sure….7 [***Prompt by saying: Sometimes children's doctors give parents records or charts with their child's weight and height. If you have these I can wait while you get them***]
Refused ……..9
Height/ length:_____Ft_____in (or _____cm)
Weight:_____lbs (or _____Kg)

SECTION 8: DEMOGRAPHICS

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

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

REFERENCE Date _____/_____/_____

32. Do you consider your child 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)

33.I am going to read a list of racial categories. Which one or more of the following do you consider your child 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)

34. What was your child's main type of health care coverage during (12 weeks before Reference Date_____/_____/_____ and 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

I have just a few more questions about the parent or guardian who cares for [child's name] most often. Because education and income can affect access to healthcare, I'd like to ask you about a couple of questions on these subjects.

35. What is the highest grade or year of school that any of the household members completed? **Please answer this question based on the highest level of education in your household**

___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

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

REFERENCE Date _____/_____/_____

___9 Refused

Because income can affect access to healthcare, I'd like to ask you about annual income.

36. In your child's home, what is the household income from all sources? **READ EACH RESPONSE IN ORDER UNTIL RESPONDENT AGREES.**

___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!

37. Comments:
_____

_____
_____

_____
_____

_____
_____

_____
_____

38. Interview Completed? € Yes € No

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

40. 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

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

REFERENCE Date _____/_____/_____

- 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

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

REFERENCE Date _____/_____/_____

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