**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

**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

*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 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

*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?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  ***[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***

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  |  |  |  |  |  |  |  |
| 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 \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_]?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***[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.

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

**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 child’s household have diarrhea?

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,*** 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?

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

 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 |
| 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 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

**Section 6: Medical History**

**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)***

|  |  |  |
| --- | --- | --- |
| **[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]**

|  |  |  |
| --- | --- | --- |
|  |  | ***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 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 :

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

**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.

|  |  |  |
| --- | --- | --- |
| ***[DO NOT READ LIST]*** |  | **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:   |  |  |  |  |  |
| 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 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]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **READ LIST** | **Yes** | **No** | **DK/NS** | **Refused** |
| Congenital heart diseaseSpecify:  |  |  |  |  |
| 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.**

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  |
| \_\_\_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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

 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