

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

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

€ 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 ____/____/____

<i>Campylobacter</i>	1	2	7	9
<i>E. coli</i>	1	2	7	9
<i>Listeria</i>	1	2	7	9
<i>Salmonella</i>	1	2	7	9
<i>Shigella</i>	1	2	7	9
<i>Vibrio</i>	1	2	7	9
<i>Yersinia</i>	1	2	7	9
<i>Cryptosporidium</i>	1	2	7	9
<i>Giardia</i>	1	2	7	9
<i>Rotavirus</i>	1	2	7	9
<i>Norovirus</i>	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 >5/week	Sometimes 2-5 /week	Rarely <2/ week	Never Never	DK/NS	Refused
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 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)

€ 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 ____/____/____

		<i>If yes, How many weeks prior to (Reference Date ____/____/____) did your child take this antibiotic</i>		
[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		<i>If yes, How many weeks prior to (Reference Date ____/____/____) did your child take this</i>		

€ CASE € CONTROL

Patient ID: _____

State ID: _____

REFERENCE Date ____/____/____

[DO NOT READ LIST]		<i>antibiotic</i>		
		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			
Roloids	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, (Tranlycypromine)	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**]

Refused9

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