



(affix label here)

Patient ID Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Site	Sub-site	Sequential ID				

## SEARCH Health Questionnaire – Young Adult Version (age 18 and older)

- ◆ The purpose of this questionnaire is to learn more about young adults who have diabetes.
- ◆ In the questionnaire, the term “doctor” refers to the doctor or other health care provider, such as a nurse.

### CO-MORBIDITIES/COMPLICATIONS

1. Have you ever been tested for any genes related to diabetes?

1  Yes →

1a. Results:

1  Don't know

1b. When was the test done?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Year			

1c. Where was this test done?

2  No

3  Don't know

2. Has a doctor ever told you that you have high cholesterol or an abnormal amount of fat in your blood?

1  Yes →

2a. If yes, has a doctor ever prescribed medicine for high cholesterol or high fat?

1  Yes      2  No      3  Don't know

2b. Are you now taking prescribed medicine for high cholesterol or high fat?

1  Yes      2  No      3  Don't know

2c. Has a doctor ever recommended changes in your diet to lower cholesterol?

1  Yes      2  No      3  Don't know

2  No

3  Don't know

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0904).

3. Has a doctor ever told you that you have high blood pressure?

1  Yes →

3a. If yes, has a doctor ever prescribed any medicine for high blood pressure?

1  Yes      2  No      3  Don't know

3b. Are you now taking any medicine for high blood pressure?

1  Yes      2  No      3  Don't know

2  No

3  Don't know

4. Has a doctor ever told you that you had any of the following? (*check yes or no for each one*)

1  Yes      2  No      Addison's Disease

1  Yes      2  No      Asthma

1  Yes      2  No      Celiac disease

1  Yes      2  No      Hyperthyroidism (high thyroid)

1  Yes      2  No      Hypothyroidism (low thyroid)

1  Yes      2  No      Vitiligo (white skin patches)

5. Has a doctor said that diabetes has affected your kidneys?

1  Yes

2  No

3  Don't know

6. Has a doctor said that diabetes has damaged the back of your eyes, that is, the retina?

1  Yes →

6a. If yes, did this require laser treatment of the retina?

1  Yes

2  No

2  No

3  Don't know

7. Have you had any other major illness or medical conditions that we have not asked about?

1  Yes → If yes, please describe:

2  No

**Questions 8 and 9 are for FEMALES only.**

8. Have you already had your first period?

1  Yes →

8a. If yes, how old were you when you had your first period?

years old

1  Don't know

2  No

3  Don't know

9. Has a doctor ever told you that you have polycystic ovaries (PCO, PCOS)?

1  Yes

2  No

3  Don't know

## MEDICAL HISTORY

◆ **The next few questions are about emergency room and hospital visits you may have had.**

10. In the last 6 months, have you been to the emergency room for any reason?

1  Yes →

10a. How many times were you in the emergency room?

# of times

2  No

11. In the last 6 months, have you had one or more night's hospital stay for any reason?

1  Yes →

11a. How many times were you in the hospital for one or more nights?

--	--

# of times

2  No

12. In the past 6 months, have you had any severe hypoglycemia, that is, very low blood sugar that required you to get help?

1  Yes →

12a. How many times?

--	--

# of times

12b. How many times were you given an injection of glucagon – for hypoglycemia (low blood sugar)?

--	--

# of times

12c. How many times was "911" or life squad/ paramedics called for hypoglycemia?

--	--

# of times

12d. How many times did you go to an emergency room for hypoglycemia?

--	--

# of times

12e. How many times did you need to stay overnight at a hospital?

--	--

# of times

2  No

13. In the past 6 months, have you had ketoacidosis (often called DKA, frequently with high blood sugar, vomiting and shortness of breath)?

1  Yes →

13a. How many times?

--	--

# of times

13b. How many times did this result in an emergency room visit?

--	--

# of times

13c. How many times did this result in one or more night's hospital stay?

--	--

# of times

2  No

## MEDICATION INVENTORY

### Insulin Use

14. Were you ever treated with insulin (shots/pumps) since you were diagnosed?

1  No (*skip to question 20*)

2  Yes

15. If yes, when were insulin shots/pump started?

1  At diagnosis

2  Less than 1 month after diagnosis

3  Within 1-6 months after diagnosis

4  Within 6-12 months after diagnosis

5  1 year or more after diagnosis

16. Did you ever stop taking insulin?

1  No (*skip to question 20*)

2  Yes

17. If yes, did that happen...

1  Less than 1<sup>st</sup> month after diagnosis

2  1-6 months after diagnosis

3  6-12 months after diagnosis

4  1 year or more after diagnosis

18. How long were you off insulin?

1  Less than 1 month

2  1-6 months

3  6-12 months

4  1 year or more

19. Did you ever have any episodes of ketoacidosis (DKA) when insulin was stopped?

- 1  Yes
- 2  No
- 3  Don't know

20. How do you currently treat your diabetes? Do you use: *(check yes or no for each)*

- 20a. Diabetes tablets (pills)      1  Yes    2  No
- 20b. Insulin shots, pump, or pen    1  Yes    2  No
- 20c. Diet (meal plan)                1  Yes    2  No
- 20d. Exercise                            1  Yes    2  No

20e. Other (what?) →

21. If you are currently taking insulin, how often do you take insulin each day on average? *(if you are not currently taking insulin, go to question 24)*

- 1  1 time a day      4  More than 3 times a day
- 2  2 times a day    5  Insulin pump
- 3  3 times a day

22. How do you take insulin? *(check all that apply)*

- 1  22a. With a syringe (needle)
- 2  22b. With an insulin pump
- 3  22c. With an insulin pen

23. We would like to know the dose of insulin (number of units) that you took yesterday. *(If you use an insulin pump, record the bolus amounts in 23a – 23e, and record the total 24-hour basal dose in 23f. This may require filling out a worksheet of hourly basal rates to determine the total basal dose.)*

Worksheet		
23a.	Breakfast	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
23b.	Lunch	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
23c.	Dinner	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
23d.	Bedtime	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
23e.	Other	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
23f.	Pump	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
<b>Total insulin:</b>		

## Prescribed Medications

24. Are you taking prescribed medication(s) including insulin?

1  Yes (If Yes, document up to 10 medications below. If you are taking insulin, be certain to include all types or preparations.)

2  No (if No, skip to question 25)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

## Diabetes Education

◆ The next few questions are about what you have been taught about diabetes.

25. In the past 12 months have you met with a diabetes nurse or diabetes educator?      1  Yes    2  No    3  Don't know

26. In the past 12 months have you met with a dietician or nutritionist, or talked to someone in detail about your diet?

1  Yes →

26a. When you were staying one or more nights in the hospital      1  Yes    2  No    3  Don't know

26b. As an outpatient      1  Yes    2  No    3  Don't know

2  No

27. In the past 12 months, which of the following types of diabetes information have you received from your doctor's office or health care plan? *(check all that apply)*

- 1  Information about diabetes camp
- 1  Information about diabetes support groups
- 1  Written materials about diabetes such as pamphlets or newsletters
- 1  Videos or audio tapes
- 1  Reminder about upcoming appointments
- 1  A copy or explanation of diabetes laboratory or test results
- 1  Diabetes information or advice by telephone
- 1  Diabetes information or advice in person
- 1  How to get diabetes information on the internet
- 1  Information about diabetes research studies other than this study

28. How would you rate your diabetes control: Would you say:

- 1  Excellent
- 2  Good
- 3  Fair
- 4  Needs much work

### Home Diabetes Care

◆ Here are some questions about your diabetes care outside of the doctor's office.

29. Do you live or stay in more than one home on a regular basis? For example, if your parents are separated, this would include spending the weekend with your other parent. It would also include other relatives you might live or stay with on a regular basis (at least once per month).

1  Yes →

29a. If yes, do you live in:

- 1  2 households
- 2  3 or more households
- 3  Don't know

2  No, live in one household



30. How much of your own diabetes care do you do for yourself? Would you say: *(check one response)*

- 1  None
- 2  Less than 25%
- 3  25-75%
- 4  More than 75%
- 5  All *(skip to question 32)*

31. Who helps you with your diabetes care?

- |                                  |                                |                               |
|----------------------------------|--------------------------------|-------------------------------|
| 31a. Parent/step parent/guardian | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 31b. Grandparent                 | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 31c. Brother/sister              | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 31d. Another person              | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |

32. Do you test your blood sugar or glucose at home or any place other than the doctor's office?

- 1  Yes →
- 2  No *(if no, go to question 33)*

32a. How often is your blood sugar checked with a glucose meter (glucometer)? *(check one)*

- 1  Less than once a week
- 2  Less than once a day
- 3  1-2 times a day
- 4  3 times a day
- 5  4-6 times a day
- 6  7 or more times a day
- 7  Only when you are sick



## Provider Care

◆ These questions are about the doctors or health care providers that you see.

33. Who do you usually see for your diabetes care? *(Check only one response)*

- 1  Pediatric endocrinologist/diabetologist (diabetes specialist)
- 2  Pediatrician
- 3  Family practice doctor
- 4  General practice doctor
- 5  Adult endocrinologist/diabetologist (diabetes specialist)
- 6  Internist
- 7  Nurse practitioner/physician's assistant
- 8  Nurse diabetes educator
- 9  Traditional medicine man, healer, or curandero/curandera
- 10  Dietician/Nutritionist
- 11  Other *(specify)* →
- 12  Don't know/unsure of what kind of doctor
- 13  None/no source of medical care

34. Who do you usually see for your medical needs not related to diabetes? *(Check only one response)*

- 1  Pediatric endocrinologist/diabetologist (diabetes specialist)
- 2  Pediatrician
- 3  Family practice doctor
- 4  General practice doctor
- 5  Adult endocrinologist/diabetologist (diabetes specialist)
- 6  Internist
- 7  Nurse practitioner/physician's assistant
- 8  Nurse diabetes educator
- 9  Traditional medicine man, healer, or curandero/curandera
- 10  Dietician/Nutritionist
- 11  Other *(specify)* →
- 12  Don't know/unsure of what kind of doctor
- 13  None/no source of medical care

◆ Below are some questions about how often you see various medical providers.

35. Who provides medical care for you? (For each provider checked, indicate the number of visits you had with this provider in the **past 6 months.**)

- |      |                                |                               |   |   |                                     |
|------|--------------------------------|-------------------------------|---|---|-------------------------------------|
| 35a. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Pediatric endocrinologist/<br>diabetologist (diabetes specialist) | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35b. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Pediatrician  | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35c. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Family practice doctor  | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35d. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | General practice doctor   | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35e. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Adult endocrinologist/<br>diabetologist (diabetes specialist)     | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35f. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Internist   | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35g. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Nurse practitioner/physician's<br>assistant                       | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35h. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Nurse diabetes educator   | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35i. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Traditional medicine man, healer,<br>or curandero/curandera       | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35j. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Dietician   | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35k. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Eye doctor (optometrist,<br>ophthalmologist)                      | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35l. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Psychiatrist, psychologist, or<br>mental health counselor         | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |
| 35m. | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | Other <input type="text"/><br>(specify)                           | <input type="text"/> <input type="text"/> | # of visits in the<br>last 6 months |

## Insurance and Cost of Diabetes Supplies

36. What kind of health insurance or health care plan do you have?

- |   |                                |                               |
|---|--------------------------------|-------------------------------|
| 36a. Medicaid/Medicare/State-funded/ other Federally-funded | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36b. Private insurance, through employer                    | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36c. Private insurance, purchased on your own               | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36d. Military   | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36e. School-based insurance                                 | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36f. Tribe/Indian Health Service                            | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36g. Any other or type unknown                              | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| 36h. None ( <i>if none, go to question 38</i> )             | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |

37. Does your health insurance or health care plan pay for any of your... (*check yes, no or don't know for each one*)

- |  |                                |                               |                                       |
|--|--------------------------------|-------------------------------|---------------------------------------|
| 37a. Diabetes medicine/insulin               | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 37b. Syringes/pens/needles                   | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 37c. Insulin pump and supplies               | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 37d. Home glucose monitor                    | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 37e. Monitor strips and related supplies     | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 37f. Diabetes education                      | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 37g. <input type="checkbox"/> Not applicable |                                |                               |                                       |

38. About how much do you spend, on average, in a typical month on diabetes medicine and supplies? (*This does not include costs that are covered or later reimbursed by your insurance plan.*)

- 1  \$0 (none)
- 2  \$1 - \$19
- 3  \$20 - \$49
- 4  \$50 - \$99
- 5  \$100 - \$199
- 6  \$200 or more
- 7  Don't know

39. How satisfied are you with your current insurance coverage? Would you say:

- 1  Very satisfied
- 2  Satisfied
- 3  Somewhat satisfied
- 4  Not satisfied

40. Has your main health insurance plan changed in the last 6 months?

- 1  Yes (*if yes, go to question 40a*)
- 2  No (*if no, go to question 41*)
- 3  Don't know
- 4  Don't want to answer

40a. What were the reasons your health insurance plan changed? (*check all that apply*)

- 1  Employer stopped offering this plan
- 1  Doctor left this plan
- 1  Unhappy with benefits/coverage
- 1  Too difficult to get care
- 1  Moved
- 1  Change in jobs
- 1  Other (*specify*) →
- 1  Don't know
- 1  Don't want to answer

41. Has your main diabetes provider changed in the last six months?

- 1  Yes (*if yes, go to question 41a*)
- 2  No (*if no, go to question 42*)
- 3  Don't know
- 4  Don't want to answer

41a. What were the reasons you had a change in diabetes provider? (*check all that apply*)

1  No longer covered by health plan

1  Too difficult to get care

1  Not satisfied with care

1  Moved

1  Other (*specify*) →

1  Don't know

1  Don't want to answer

◆ **These questions deal with your parents' education.**

42. What is the highest degree or level of school your **mother/guardian** has COMPLETED?

1  No schooling completed

2  Nursery school to 4<sup>th</sup> grade

3  5<sup>th</sup> grade or 6<sup>th</sup> grade

4  7<sup>th</sup> grade or 8<sup>th</sup> grade

5  9<sup>th</sup> grade

6  10<sup>th</sup> grade

7  11<sup>th</sup> grade

8  12<sup>th</sup> grade, NO DIPLOMA

9  High school graduate (high school diploma) or equivalent (for example: GED)

10  Business/technical school

11  Some college credit but less than 1 year

12  1 or more years of college, no degree

13  Associate degree (for example: AA, AS) (2-year)

14  Bachelor's degree (for example: BA, AB, BS) (4-year)

15  Master's degree (for example: MA, MS, MEng, MEd, MSW)

16  Professional or doctorate degree (for example: MD, DDS, JD, PhD, EdD)

17  Don't know

43. What is the highest degree or level of school your **father/guardian** has COMPLETED?

- 1  No schooling completed
- 2  Nursery school to 4<sup>th</sup> grade
- 3  5<sup>th</sup> grade or 6<sup>th</sup> grade
- 4  7<sup>th</sup> grade or 8<sup>th</sup> grade
- 5  9<sup>th</sup> grade
- 6  10<sup>th</sup> grade
- 7  11<sup>th</sup> grade
- 8  12<sup>th</sup> grade, NO DIPLOMA
- 9  High school graduate (high school diploma) or equivalent (for example: GED)
- 10  Business/technical school
- 11  Some college credit but less than 1 year
- 12  1 or more years of college, no degree
- 13  Associate degree (for example: AA, AS) (2-year)
- 14  Bachelor's degree (for example: BA, AB, BS) (4-year)
- 15  Master's degree (for example: MA, MS, MEng, MEd, MSW)
- 16  Professional or doctorate degree (for example: MD, DDS, JD, PhD, EdD)
- 17  Don't know

44. Which of these categories best describes the total income of all persons living in your household, including yourself for the past 12 months? (*Check only one category.*)

- 1  Less than \$5,000
- 2  \$5,000 through \$11,999
- 3  \$12,000 through \$15,999
- 4  \$16,000 through \$24,999
- 5  \$25,000 through \$34,999
- 6  \$35,000 through \$49,999
- 7  \$50,000 through \$74,999
- 8  \$75,000 through \$99,999
- 9  \$100,000 and greater
- 10  Don't know
- 11  Prefer not to answer



45. How many people are currently living in your household, including yourself?

45a. Total number of people

45b. Number of children (less than 18)

45c. Number of adults

45c(1). Of the number of adults, how many bring income into the household?

46. Are you participating in another research study?

1  Yes 46a. If yes, what study? →

2  No

◆ As a part of the study, we will be contacting you in the future. It would be helpful to us if you could provide us with the names, addresses, and phone numbers of two people who could contact you even if you move.

Name

Relationship

Address:

P.O. Box

Street

Apt. #

City

State

Zip Code

Email Address

Phone # (best)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(area code)			ext.
Phone # (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(area code)			ext.
Phone # (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(area code)			ext.

Name

Relationship

Address:

<input type="text"/>	<input type="text"/>	<input type="text"/>
P.O. Box	Street	Apt. #
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	Zip Code

Email Address

Phone # (best)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(area code)			ext.
Phone # (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(area code)			ext.
Phone # (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(area code)			ext.

**Thank you for completing this questionnaire.**

**FOR STUDY USE ONLY**

Date Completed

Month

Day

Year

Completed by

Date Reviewed

Month

Day

Year

Reviewer Code

Date Entered

Month

Day

Year

Data Entry Code