

Community-associated *Clostridium difficile* Infection (CDI) Surveillance Health Interview

CALL LOG

Telephone number: _____

	Date (mm/dd/yy)	Time 1 (circle am or pm)	Time 2
Day 1:	_____	_____ am/pm	_____ am/pm
Day 2:	_____	_____ am/pm	_____ am/pm
Day 3:	_____	_____ am/pm	_____ am/pm
Day 4:	_____	_____ am/pm	_____ am/pm
Day 5:	_____	_____ am/pm	_____ am/pm

Call no more than 10 times with 2 attempts per day for 5 days over a two week period: at least one weekday between 5-8pm; and one weekend day (Sat: 9am-6pm or Sun: 1pm-8pm).

Call back at _____ (day) _____ (time)

Call back at _____ (day) _____ (time)

Call back at _____ (day) _____ (time)

Public reporting burden of this collection of information is estimated to average 45 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 (0920-0892).

ENROLLEE INTERVIEW – THIS PORTION WILL BE TRANSFERRED TO CDC

SECTION 1: IDENTIFIERS (TO BE FILLED OUT BY EIP STAFF)

- 1. Patient ID: _____
- 2. State ID: _____
- 3. Provider ID: _____
- 4. Lab ID: _____
- 5. Specimen ID (accession number): _____
- 6. Specimen Collection Date / /
(mm/dd/yyyy)
- 7. Age
- 8. Sex Male Female

HAVE A CALENDAR IN FRONT OF YOU.

I will ask you questions about [your/your child's] illness, healthcare contacts, household contacts, other exposures and medical history. It may be difficult to remember, but I would like your best guess for each question. Because I will be asking about specific dates around the time [your/your child's] diarrhea began (initial specimen collection date), it may be helpful for you to have a calendar or datebook in front of you. Do you need a minute to get any of these items?

If interviewees gravitate toward answering that they don't know/are unsure how to answer questions, encourage them to try to remember one way or another. [See Interviewer Manual]

Specimen collection date: / /
(mm/dd/yyyy)

8 weeks before specimen collection / /

12 weeks before specimen collection / /

Date diarrhea began: / /
(mm/dd/yyyy)

1 week before diarrhea began / /

2 weeks before diarrhea began / /

12 weeks before diarrhea began / /

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____

SECTION 2: SCREENING QUESTIONS (PLEASE REFER TO THE SCREENING FORM. IF PATIENT ELIGIBLE PLEASE PROCEED)

SECTION 3: ILLNESS QUESTIONS

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

11. Did [you/your child] have diarrhea at the time [your/your child's] stool specimen was collected on [specimen collection date ____/____/____]? We define diarrhea as 3 or more loose stools in a 24 hour period.

- Yes.....1 **(Go to Q. 11A)**
- No2 **(Go to Q. 11D)**
- Don't know/Not sure.....7 **(Go to Q.12 and use initial date of specimen collection as reference date.)**
- Refused.....9 **(Go to Q.12 and use initial date of specimen collection as reference date.)**

11A. **If yes**, Do [you/your child] remember when [your/your child's] diarrhea began?

- Yes.....1 **(If Yes –fill in date diarrhea began)**
- No2 **(fill in date diarrhea began with date of specimen collection.)**
- Don't know/Not sure.....7 **(fill in date diarrhea began with date of specimen collection.)**
- Refused.....9 **(fill in date diarrhea began with date of specimen collection.)**

Date diarrhea began: ____/____/____
(mm/dd/yyyy)

1 week before ____/____/____

2 weeks before ____/____/____

12 weeks before ____/____/____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

11B. How many days did [your/your child's] diarrhea last?

11C. On the worst day of [your/your child's] diarrhea, what was the approximate number of stools [you/your child] had in a 24-hour period? **(Go to Q.12)**

- ≥3-<5 stools1
- 5-10 stools2
- >10 stools.....3
- Don't know/Not sure.....7
- Refused.....9

11D. **If no to Q.11, why was [your/your child's] stool tested? (Go to Q.12)**

12. Did [you/your child] have any of the following symptoms associated with [your/your child's] *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: _____

13. Were [you/your child] hospitalized overnight for [your/your child's] *C. difficile* illness?

- Yes.....1
- No2
- Don't know/Not sure.....7
- Refused.....9

14. At the time of [your/your child's] *C. difficile* diagnosis, were [you/your child] told by a doctor or healthcare provider that [you/your child] had any other stomach [enteric, gastrointestinal] infection?

- Yes.....1
- No2 **(Go to Q.15)**
- Don't know/Not sure.....7 **(Go to Q.15)**
- Refused.....9 **(Go to Q.15)**

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

14A. **If yes**, what was the name of the infection?

[Read list if necessary]	Yes	No	DK/NS	Refused
<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
Other	1	2		

Specify: _____

SECTION 4: HEALTHCARE CONTACTS

Now I will ask you questions about [you/your child] healthcare contacts in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), which would be from [12 weeks before date] to [date diarrhea began], and ALSO in the 1 week before [your/your child's] diarrhea began (initial specimen collection date), which would be from [1 week before date] to [date diarrhea began].

15. Did [you/your child] receive care in any doctor's office, dentist, hospital, nursing home, or any other medical facility in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

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

15A. **If yes**, was it in the 1 week before [your/your child's] diarrhea began (initial specimen collection date)?

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

15B. What type of facility did [you/your child] visit in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

[READ LIST]	Yes	No	DK/NS	Refused	If yes , in the 1 week before	
					Yes	No
Hospital	1	2	7	9	1	2
Emergency department	1	2	7	9	1	2
Doctor's office	1	2	7	9	1	2
Dentist	1	2	7	9	1	2
Long term care (skilled nursing facility)	1	2	7	9	1	2
Hemodialysis facility	1	2	7	9	1	2
Other facility	1	2			1	2

Specify: _____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

15C. During those visits in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date) did [you/your child] have any of the following procedures performed?

[READ LIST]	Yes	No	DK/NS	Refused	If yes, in the 1 week before	
					Yes	No
Upper Endoscopy (Did the doctors pass a tube through your mouth or nose into your stomach?)	1	2	7	9	1	2
Colonoscopy or Sigmoidoscopy (Did the doctors pass a tube into your rectum to look into your colon/bowel?)	1	2	7	9	1	2
X-ray that required GI Prep (Did you have an X-ray performed where you had to swallow something first?)	1	2	7	9	1	2
Chemotherapy	1	2	7	9	1	2
Surgery in an operating room → If yes, did [you/your child] take an antibiotic before surgery?	1	2	7	9	1	2
Oral Surgery → If yes, did [you/your child] take an antibiotic before surgery?	1	2	7	9	1	2
Other procedures	1	2			1	2

Specify: _____

16. Did [you/your child] visit or accompany anyone to a doctor's office, dentist, hospital, nursing home, or any other medical facility in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

- Yes.....1
- No2 (**Go to Q.17**)
- Don't know/Not sure.....7 (**Go to Q.17**)
- Refused.....9 (**Go to Q.17**)

16A. **If yes**, was it in the 1 week before [your/your child's] diarrhea began (initial specimen collection date)?

- Yes.....1
- No2
- Don't know/Not sure.....7
- Refused.....9

16B. What type of facility did [you/your child] visit or accompany someone to in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

[READ LIST]	Yes	No	DK/NS	Refused	If yes, in the 1 week before	
					Yes	No
Hospital	1	2	7	9	1	2
Emergency department	1	2	7	9	1	2
Doctor's office	1	2	7	9	1	2
Dentist	1	2	7	9	1	2
Long term care (skilled nursing facility)	1	2	7	9	1	2
Hemodialysis facility	1	2	7	9	1	2
Other facility	1	2			1	2

Specify: _____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____

SECTION 5: HOUSEHOLD CONTACTS

The next few questions are about [you/your child] and persons who lived with [you/your child].

17. Including [yourself/your child], how many persons were spending at least 50% of their nights in [your/your child's] home in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?
(If patient lived alone, only one person in the household, go to Q.22)

18. How many household members 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+

If children <4 years of age are present in household go to Q.18A; if no children <4 years of age, go to Q.19

18A. Were any of the children in diapers?
Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

18B. Did any of the children attend a group childcare setting or daycare?
Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

18B1. **If yes**, what type of childcare setting? [Read list if necessary]
Home..... 1
Center 2
Other 3
Specify: _____
Don't know/Not sure 7
Refused..... 9

19. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did any household member stay overnight in a hospital?
Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

20. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did any household member stay overnight in another healthcare institution (long-term care facility, nursing home, chronic care, or rehab unit)?
Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

21. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did anyone else in [your/your child's] household have diarrhea?

- Yes.....1
- No2 (**Go to Q.22**)
- Don't know/Not sure.....7 (**Go to Q.22**)
- Refused.....9 (**Go to Q.22**)

21A. **If yes**, did [you/your child] assist this person with toileting (including diaper changes)?

- Yes.....1
- No2
- Don't know/Not sure.....7
- Refused.....9

21B. Was this person diagnosed with *C. difficile*?

- Yes.....1
- No2
- Don't know/Not sure.....7
- Refused.....9

22. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [your/your child's] household have any pets?

- Yes.....1
- No2 (**Go to Q.23**)
- Don't know/Not sure.....7 (**Go to Q.23**)
- Refused.....9 (**Go to Q.23**)

22A. **If yes**, which of the following pets:

[READ LIST]	Yes	No	DK/NS	Refused
Dog	1	2	7	9
Cat	1	2	7	9
Other pet	1	2		

Specify: _____

22B. Did [your/your child's] pet have diarrhea in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

- Yes.....1
- No2
- Don't know/Not sure.....7
- Refused.....9

23. Did [you/your child] work or volunteer, in any capacity, at a hospital, other medical facility, or in any facility where patient care is provided in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

- Yes.....1
- No2 (**Go to Q.24**)
- Don't know/Not sure.....7 (**Go to Q.24**)
- Refused.....9 (**Go to Q.24**)

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

23A. **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: _____

23B. Did [your/your child's] job involve direct patient care?

- Yes.....1
- No2 (**Go to Q.24**)
- Don't know/Not sure.....7 (**Go to Q.24**)
- Refused.....9 (**Go to Q.24**)

23B1. **If yes**, what was [your/your child's] main job?

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

(If patient lived alone, only one person in the household, go to Q.25)

24. Did any of [your/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 [your/your child's] diarrhea began (initial specimen collection date)?

- Yes.....1
- No2 (**Go to Q.25**)
- Don't know/Not sure.....7 (**Go to Q.25**)
- Refused.....9 (**Go to Q.25**)

24A. **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: _____

24B. Did their job involve direct patient care?

- Yes.....1
- No2 (**Go to Q.25**)
- Don't know/Not sure.....7 (**Go to Q.25**)
- Refused.....9 (**Go to Q.25**)

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____

24B1. **If yes**, what was their main job?

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

25. Did [you/your child] work or volunteer in a veterinary clinic, on a farm, or in other profession caring for animals in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

(If patient lived alone, only one person in the household, go to Q.27)

26. Did any of [your/your child's] household members work or volunteer in a veterinary clinic, on a farm, or in other profession caring for animals in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

SECTION 6: OTHER EXPOSURES

I'd like to change direction now and ask you about some other exposures [you/your child] may have had.

27. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [you/your child] travel outside of the US?

Yes.....1
No2 (Go to Q.28)
Don't know/Not sure.....7 (Go to Q.28)
Refused.....9 (Go to Q.28)

27A. **If yes**, where did [you/your child] travel to and when did [you/your child] travel?

Country: _____ Date: ____/____/____ to Date: ____/____/____
Country: _____ Date: ____/____/____ to Date: ____/____/____
Country: _____ Date: ____/____/____ to Date: ____/____/____

28. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [you/your child] visit a farm, petting zoo, state, county, or local fair, or other events at which animals were present?

Yes.....1
No2
Don't know/Not sure.....7
Refused.....9

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

29. In the 12 weeks before [you/your child's] diarrhea began (initial specimen collection date), did [you/your child] have any contact with any of the following live animals?

[READ LIST]	Yes	No	DK/NS	Refused
Chicken/baby chick/turkey	1	2	7	9
Cow/bull/steer/calf	1	2	7	9
Goat/sheep/lamb	1	2	7	9
Pig	1	2	7	9
Horse	1	2	7	9

30. In a typical week how frequently do [you/your child] consume the following foods?

[READ LIST]	Often	Sometimes	Rarely	Never	DK/NS	Refused
Beef	1	2	3	4	7	9
Pork	1	2	3	4	7	9
Lamb	1	2	3	4	7	9
Chicken	1	2	3	4	7	9
Turkey	1	2	3	4	7	9
Deli meats (pre-sliced or sliced at meat counter)	1	2	3	4	7	9
Eggs	1	2	3	4	7	9
Milk	1	2	3	4	7	9

SECTION 7: MEDICAL HISTORY

The next set of questions are about medications [you/your child] may have been taking in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date). Medicine bottles or records may help you remember about specific medications. Would you like to gather this information before we go on?

31. Did [you/your child] take any antibiotics in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)?

- Yes..... 1
- No2 (Go to Q.32)
- Don't know/Not sure.....7 (Go to Q.32)
- Refused.....9 (Go to Q.32)

31A. **If yes**, how was this antibiotic obtained? [Read list if necessary]

- Prescribed for the problem that [you/ your child] had 1
- Borrowed from a friend or relative 2
- Prescribed in the past for another problem 3
- Other 4

Specify: _____

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

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

31B. Why did [you/your child] take this antibiotic?

[DO NOT READ LIST]

	Yes	No	DK/NS	Refused
Ear, sinus, upper respiratory infection	1	2	7	9
Bronchitis/ pneumonia	1	2	7	9
Urinary tract infection	1	2	7	9
Skin infection	1	2	7	9
Acne	1	2	7	9
Dental cleaning/oral surgery	1	2	7	9
Surgery	1	2	7	9
Other	1	2		

Specify: _____

31C. Which antibiotic(s) did [you/your child] take in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date)? **[DO NOT READ LIST]**

	Yes	<i>If yes, in the</i> 2 weeks before			Yes	<i>If yes, in the</i> 2 weeks before	
		Yes	No			Yes	No
Amoxicillin	1	1	2	Floxin	1	1	2
Amoxicillin/Clavulanate	1	1	2	Keflex	1	1	2
Ampicillin	1	1	2	Keftab	1	1	2
Augmentin	1	1	2	Levofloxacin	1	1	2
Azithromycin	1	1	2	Levoquin	1	1	2
Bactrim	1	1	2	Monurol	1	1	2
Biaxin	1	1	2	Metronidazole	1	1	2
Ceclor	1	1	2	Norfloxacin or Norflox	1	1	2
Cefaclor	1	1	2	Ofloxacin or Oflox	1	1	2
Cefadroxil	1	1	2	Omnicef	1	1	2
Cefdinir	1	1	2	Penicillin or Pen VK	1	1	2
Ceftin	1	1	2	Pediazole	1	1	2
Cefixime	1	1	2	Septra	1	1	2
Cefuorixime	1	1	2	Suprax	1	1	2
Cefzil	1	1	2	Tetracycline	1	1	2
Cefprozil	1	1	2	Tequin	1	1	2
Cephalexin	1	1	2	Trimox	1	1	2
Cephradine	1	1	2	Trimethoprim/Sulfa	1	1	2
Ciprofloxacin or Cipro	1	1	2	Vancomycin	1	1	2
Clarithromyc	1	1	2	Zagam	1	1	2
Cleocin	1	1	2	Zithromax or Z-Pak	1	1	2
Clindamycin	1	1	2				
Dapsone	1	1	2	Other antibiotic 1	1	1	2
Doxycycline	1	1	2	Specify: _____			
Duricef	1	1	2	Other antibiotic 2	1	1	2
Erythromycin	1	1	2	Specify: _____			
Erythromycin/sulfa	1	1	2	Don't know/Not sure	1		
Flagyl	1	1	2	Refused	1		

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

32. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [you/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 Tums, Maalox, Mylanta, Tagamet, Zantac, Prilosec, or Nexium.

- Yes..... 1
- No 2 (Go to Q.33)
- Don't know/Not sure..... 7 (Go to Q.33)
- Refused..... 9 (Go to Q.33)

32A. **If Yes**, please specify which medicine [you/your child] regularly took in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date).

[Read list if necessary]	Yes	No	DK/NS	Refused	If yes , in the 2 weeks before	
					Yes	No
Aciphex/rabeprazole	1	2	7	9	1	2
Alka-Seltzer	1	2	7	9	1	2
Maalox	1	2	7	9	1	2
Mylanta	1	2	7	9	1	2
Nexium/esomeprazole	1	2	7	9	1	2
Pepcid/famotidine	1	2	7	9	1	2
Prevacid/lansoprazole	1	2	7	9	1	2
Prilosec/omeprazole	1	2	7	9	1	2
Protonix/pantoprazole	1	2	7	9	1	2
Roloids	1	2	7	9	1	2
Tums	1	2	7	9	1	2
Tagamet/cimetidine	1	2	7	9	1	2
Zantac/ranitidine	1	2	7	9	1	2
Other	1	2			1	2

Specify: _____

33. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [you/your child] regularly take any laxatives? We define regular use as use of the product at least 3 days per week

- Yes..... 1
- No 2 (Go to Q.34)
- Don't know/Not sure..... 7 (Go to Q.34)
- Refused..... 9 (Go to Q.34)

33A. **If Yes**, please specify which medicine [you/your child] regularly took in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date). This does not include the use of supplemental fiber or Metamucil.

[Read list if necessary]	Yes	No	DK/NS	Refused	If yes , in the 2 weeks before	
					Yes	No
Alophen	1	2	7	9	1	2
Aqualax	1	2	7	9	1	2
Bisacodyl	1	2	7	9	1	2
Calube	1	2	7	9	1	2
Colace	1	2	7	9	1	2
Correctol	1	2	7	9	1	2
Docusate	1	2	7	9	1	2
Dulcolax	1	2	7	9	1	2
Other	1	2			1	2

Specify: _____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

34. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [you/your child] regularly take any anti-diarrheal drugs such as Imodium or Pepto-Bismol? We define regular use as use of the product at least 3 days per week

- Yes.....1
- No2 (Go to Q.35)
- Don't know/Not sure.....7 (Go to Q.35)
- Refused.....9 (Go to Q.35)

34A. **If Yes**, please specify which medicine [you/your child] regularly took in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date).

[Read list if necessary]	Yes	No	DK/NS	Refused	If yes, in the 2 weeks before	
					Yes	No
Antispas	1	2	7	9	1	2
Bentylol	1	2	7	9	1	2
Dimor	1	2	7	9	1	2
Imodium	1	2	7	9	1	2
Kaopectate	1	2	7	9	1	2
Levsin	1	2	7	9	1	2
Loperamide	1	2	7	9	1	2
Lopex	1	2	7	9	1	2
Lomotil	1	2	7	9	1	2
Pepto-Bismol	1	2	7	9	1	2
Other	1	2			1	2

Specify: _____

35. In the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date), did [you/your child] regularly take any non-steroidal anti-inflammatory drugs, or NSAIDS, for fever or pain? We define regular use as use of the product at least 3 days per week. This would include drugs such as aspirin, naproxen, or ibuprofen but does not include Tylenol, or acetaminophen.

- Yes.....1
- No2 (Go to Q.36)
- Don't know/Not sure.....7 (Go to Q.36)
- Refused.....9 (Go to Q.36)

35A. **If Yes**, please specify which medicine [you/your child] regularly took in the 12 weeks before [your/your child's] diarrhea began (initial specimen collection date).

[Read list if necessary]	Yes	No	DK/NS	Refused	If yes, in the 2 weeks before	
					Yes	No
Advil or ibuprofen	1	2	7	9	1	2
Aspirin	1	2	7	9	1	2
Naproxen or Aleve	1	2	7	9	1	2
Other	1	2			1	2

Specify: _____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
 1 week before ____/____/____
 2 weeks before ____/____/____
 12 weeks before ____/____/____

Patient ID: _____
 State ID: _____

Now I am going to ask you about medical conditions [you/your child] may have had in the past 2 years.

36. In the **2 years** before [your/your child's] diarrhea began (initial specimen collection date), did [you/your child] have any of the following medical conditions? **[READ LIST – including information in parentheses]**

	Yes	No	DK/NS	Refused	Year of diagnosis
Diabetes	1	2	7	9	_____
High blood pressure	1	2	7	9	_____
Chronic renal (kidney) failure	1	2	7	9	_____
→ If yes , are [you/your child] on dialysis or awaiting dialysis?	1	2	7	9	_____
Chronic pulmonary disease (COPD, emphysema, asthma)	1	2	7	9	_____
Organ transplant	1	2	7	9	_____
Bone marrow transplant	1	2	7	9	_____
Stomach ulcer (peptic/gastric ulcer disease)	1	2	7	9	_____
Stomach surgery	1	2	7	9	_____
Chronic Hepatitis C infection	1	2	7	9	_____
Chronic Hepatitis B infection	1	2	7	9	_____
Sickle cell disease (not sickle cell trait)	1	2	7	9	_____
Lupus	1	2	7	9	_____
Rheumatoid arthritis	1	2	7	9	_____
Inflammatory bowel disease (Crohn's disease, Ulcerative colitis)	1	2	7	9	_____
Heart attack	1	2	7	9	_____
Congestive heart failure	1	2	7	9	_____
Stroke	1	2	7	9	_____
Peripheral vascular disease (intermittent claudication, gangrene, peripheral arterial bypass)	1	2	7	9	_____
Leukemia or lymphoma	1	2	7	9	_____
Cancer (e.g. breast, prostate, lung cancer)	1	2	7	9	_____
Other	1	2			_____

Specify: _____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____

SECTION 8: DEMOGRAPHICS

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

37. How would you describe [your/your child's] race? **[Read list if necessary]**

Respondent may choose more than one race

- American Indian or Alaskan native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Other, Specify: _____
- Unknown
- Refused

38. Are [you/your child] of Hispanic or Latino origin?

- Yes
- No
- Don't know
- Refused

That was my last interview question. Thank you very much for your time and participation!

39. Comments: _____

40. Interview Completed? Yes No

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

42. Interviewer initials: _____

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____

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

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____

- 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

Public reporting burden of this collection of information is estimated to average 45 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 current 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

Date diarrhea began ____/____/____ (mm/dd/yyyy)
1 week before ____/____/____
2 weeks before ____/____/____
12 weeks before ____/____/____

Patient ID: _____
State ID: _____