Appendix 5. Telephone Interview Example Questionnaire – Patient Questionnaire

Form Approved
OMB No. 0920-XXXX
Exp. Date XX/XX/XXXX

Patient Questionnaire

Patient ID: _____
Initials of caller: _____

Myelogram patients:
Did you have a procedure on _____ *[date]* _____ that involved an injection on your back to take special pictures of your back?

Other patients:
Did you have a procedure on ____ *[date]* _____ that involved an injection into a joint or into your back, either to take special pictures of that joint or to help relieve pain or other symptoms?

Yes No *(circle one)*

Did you have any problems at the site of the injection within 7 days following the procedure?

Yes No *(circle one)*

Did you have any other new health complaints following the procedure?

Yes No *(circle one)*

If yes:

What type of problems were you having? *(List problems)*

_____

_____

Did you seek medical attention for any of these problems? Yes No *(circle one)*

Which doctor, clinic, or emergency room did you go to?
(Collect name, phone number, address, for doctor, clinic, or emergency room, and date of visit)
Physician Name (First, Last):_____

Name of clinic/emergency room/hospital: _____

Phone Number: _____

Street address: _____

City and State; _____

Date of visit (MM/DD/YY): _____

Please describe what happened during that visit.

_____

_____

Did you receive any antibiotics at this visit? Yes No *(circle one)*
Did you have any additional procedures? Yes No *(circle one)*
If yes, please tell me what type of procedure the doctor preformed:
_____

Were you hospitalized after this visit? Yes No *(circle one)*

If yes, collect information regarding dates of hospitalization, and name and address of hospital.

Dates of hospitalization (MM/D/YY to MM/DD/YY): _____

Name of Hospital: _____

Address of Hospital: _____

End:

Thank you very much for your time and for helping us collect this information. Goodbye.

(Hang up. Record date and time of call and any information collected.)