

Appendix 5. Telephone Interview Example Questionnaire – Patient Questionnaire

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

## **Patient Questionnaire**

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

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 performed:

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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.)***