Text Analysis Study Screeners

OMB Control No.: 0910-XXX
Expiration Date: XX/XX/20XX

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CONSUMER SCREENER

[AGE]

S1. How old were you on your last birthday?
[OPEN-ENDED]

[IF <18, TERMINATE]
[IF ≥18, CONTINUE]

[OCCUPATION]
S2. Do you currently or have you ever worked in any of the following occupations? (Select all that apply)

1. Healthcare provider (e.g., physician, nurse, counselor, physical therapist)
2. Pharmaceutical employee (e.g., Pharma Rep)
3. Department of Health and Human Services employee
4. Market research employee or advertising employee
5. None of the above [EXCLUSIVE]

[IF S2=1, 2, 3, 4, OR BLANK, SET EFLAG=0 "Ineligible" – TERMINATE]
[IF S2=5, CONTINUE]

[EDUCATION]
S3. What is the highest level of education you have completed?

1. Less than high school
2. High school graduate (high school diploma or GED)
3. Some college, but no degree
4. Associate's degree (2-year)
5. Bachelor's degree (4-year) (example: BA, BS)
6. Advanced or postgraduate degree (example: MA, MD, DDS, JD, PhD, EdD)

[GENDER]
S4. What is your gender?

1. Male
2. Female
3. Prefer not to answer

[CONTINUE]

[ETHNICITY]
S5. Are you Hispanic or Latino?
1. Yes
2. No
3. Prefer not to answer [EXCLUSIVE]

[CONTINUE]

[RACE]
S6. What is your race? You may select one or more races.
1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or Pacific Islander
5. White
6. Prefer not to answer [EXCLUSIVE]

[CONTINUE]

[HEALTH LITERACY]
S7. How confident are you filling out medical forms by yourself?
1. Not at all
2. A little bit
3. Somewhat
4. Quite a bit
5. Extremely

[CONTINUE]

[FAMILIARITY WITH FOREIGN LANGUAGES]
S8. Do you know any language other than English (for example, Spanish, French or Latin)?
1. No
2. Yes

[IF S8=1, SKIP TO S10]
[IF S8=2 CONTINUE]

S9. Please rate your familiarity with each of the following languages:

Language	**Native**	**Good**	**Fair**	**Poor**	**I do not know this language**
Latin					
Spanish					
French					

Italian					
Portuguese					
Other Language (specify):____					

S10. Have you ever been diagnosed with any of the following conditions by a medical professional?: Please select "yes" for all that apply:
[PROGRAMMERS RANDOMIZE ORDER]

Medical Condition	**Yes**
Asthma or allergic rhinitis	
Attention Deficit Hyperactivity Disorder (ADHD)	
Benign prostatic hyperplasia (men only)	
Chronic pain or arthritis	
Dementia associated with Alzheimer's disease	
Elevated intraocular pressure	
Excessive facial hair	
Eye swelling and pain	
Heart burn or acid reflux	
Hemophilia	
High blood pressure	
Hypothyroid disease	
Insomnia	
Low testosterone	
Lung disease	
Major depressive disorder	
Osteoporosis	
Overactive bladder	
Plaque psoriasis	
Prevention of organ rejection	
Type 2 diabetes	

Urinary problems	

[DISPLAY IF EFLAG=0 'INELIGIBLE']
[CLOSING FOR INELIGIBLE PARTICIPANTS]:
I'm sorry, but you are not eligible for this study. There are many possible reasons why people are not eligible. These reasons were decided earlier by the researchers. However, thank you for your interest in this study and for taking the time to answer our questions today.

[DISPLAY CONSENT SCREEN IF EFLAG=1 'ELIGIBLE']
PARTICIPANT IS TAKEN TO THE INFORMED CONSENT SCREEN: IF PARTICIPANT AGREES TO PARTICIPATE, THEY WILL BE TAKEN TO THE SURVEY

HEALTH CARE PROVIDER SCREENER

[HEALTH PROFESSIONAL]
S1. Are you a medical or health professional?
1. Yes
2. No

[IF S1=YES, CONTINUE]
[IF S1=NO, TERMINATE]

[OCCUPATION]
S2. Have you ever worked for…? (Select all that apply)
1. Department of Health and Human Services
2. U.S. Food and Drug Administration
3. Market Research Firm
4. RTI International
5. None of the above

[IF S2=1, 2, 3, 4, OR BLANK, SET EFLAG=0 "Ineligible" – TERMINATE]
[IF S2=5, CONTINUE]

S3. Have you ever been employed by a pharmaceutical company (not counting consulting work)?
1. Yes
2. No

[IF S3=1, TERMINATE]
[IF S3=2, CONTINUE]

[TYPE OF PROVIDER]
S4. Are you a…?
1. Primary Care Physician (Family Practice, Internal Medicine, General Practitioner)
2. Physician's Assistant
3. Nurse Practitioner
4. Specialist
5. All other types

[IF S4=1 CONTINUE]
[IF S4=2, 3, 4 or 5, TERMINATE]

[% TIME ON PATIENT CARE]
S5. What percentage of your time do you spend providing direct patient care?
1. Less than 50%
2. 50% or more

[IF S5=1, TERMINATE]
[IF S5=2, CONTINUE]

[YEARS IN PRACTICE]

S6. How long have you been practicing medicine?

1. 5 years or less
2. 6-10 years
3. 11-20 years
4. 21-30 years
5. 31 or more years

[CONTINUE]

[SIZE OF PRACTICE]

S7. How would you classify your practice?

1. Solo
2. Small group practice (2-10 HCPs)
3. Large group practice (>10 HCPs)

[CONTINUE]

[TYPE OF PRACTICE]

S8. Is your practice part of an academic or healthcare system?

1. Yes
2. No

[CONTINUE]

[GENDER]

S9. What is your gender?

1. Male
2. Female
3. Prefer not to answer

[CONTINUE]

[ETHNICITY]

S10. Are you Hispanic or Latino?

1. Yes
2. No
3. Prefer not to answer [EXCLUSIVE]

[CONTINUE]

[RACE]

S11. What is your race? You may select one or more races.

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or Pacific Islander
5. White
6. Prefer not to answer [EXCLUSIVE]

[CONTINUE]

[STATE OF PRACTICE]

S12. In what state are you currently practicing? If you practice in more than one state, please select the state where the majority of your practice is located:

[PROGRAM AS SINGLE PUNCH DROP DOWN MENU (ALL STATES LISTED)]

[FAMILIARITY WITH FOREIGN LANGUAGES]

S13. Do you know any language other than English (e.g., Spanish, French, Latin)?

1. No
2. Yes

[IF S13=1, SKIP TO S15]
[IF S13=2 CONTINUE]

S14. Please rate your familiarity with each of the following languages:

Language	**Native**	**Good**	**Fair**	**Poor**	**I do not know this language**
Latin					
Spanish					
French					
Italian					
Portuguese					
Other Language (specify):____					

S15. In your regular practice, do you treat patients with any of the following conditions?

Medical Condition	Yes
Asthma or allergic rhinitis	
Attention Deficit Hyperactivity Disorder (ADHD)	
Benign prostatic hyperplasia (men only)	
Chronic pain or arthritis	
Dementia associated with Alzheimer's disease	
Elevated intraocular pressure	
Excessive facial hair	
Eye swelling and pain	
Heart burn or acid reflux	
Hemophilia	
High blood pressure	
Hypothyroid disease	
Insomnia	
Low testosterone	
Lung disease	
Major depressive disorder	
Osteoporosis	
Overactive bladder	
Plaque psoriasis	
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Urinary problems	

Closing Scripts

[CLOSING FOR INELIGIBLE PARTICIPANTS]:
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[DISPLAY CONSENT SCREEN IF EFLAG=1 'ELIGIBLE']
PARTICIPANT IS TAKEN TO THE INFORMED CONSENT SCREEN: IF PARTICIPANT AGREES TO PARTICIPATE, THEY WILL BE TAKEN TO THE SURVEY