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 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.)