Instructions for Completing *AI/AN Flu Case-Control Interview Questionnaire*

Interview Log Sheet

Do NOT send this Log Sheet to AIP; retain at the Health Department

Patient name: _____ **Case ID #: _____**

DOB: mm / dd / yyyy

Proxy name: _____

Phone numbers: **Home _____**

Cell _____

Work _____

Date including the day of the week	Time	Interviewer name and phone number	Comments (i.e., partially completed, requests call back at a better time, etc.)

Attempts made:

- ☐ 1. M-F during the workday AM
- ☐ 2. M-F during the workday PM on a different day
- ☐ 3. Weekend anytime
- ☐ 4. Evening
- ☐ 5. Evening on a different day

****Control to be discarded if they (or their proxy) cannot be reached after these five attempts are made over a period of 2 weeks.**

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Instructions for data recording:

- Prior to calling, consider filling in the dates for Questions 2-4; writing in the Patient's name; marking out the other sex/gender pronoun; and making sure you have a good contact number for respondents who may have any questions about the study.
- For some questions, there is the option to select "Not Applicable". Some of those questions are already part of a skip patterns; others are questions intended for a certain age-group.

Instructions for data transfer:

- Keep the **original** interview form at your health department; including the cover sheet with Patient/Proxy contact information
- Prior to making a copy of the form to send to CDC/AIP, **redact (blacken out)** the Patient's Name and Proxy's Name, if applicable, in Section I; Proxy Name and Phone Number in Section II, if applicable; and then any other marks on the form that would specific the patient's name/identity.

#	Date Updated	Read answer options	What Appears on Form	Description/Instructions
PRIOR TO THE INTERVIEW				
			Study ID	Follow the convention of each case as XX-001 for case #1 from state XX Each associated control will then be listed after the decimal point; e.g., AK-001 is the first case; AK-001.1 and AK-001-.2 are the two outpatient controls associated with case #1 from Alaska (AK); 001-.3 through .5, will be the three hospitalized controls
			Patient name	Name of the patient
			Specimen collection date	MM/DD/YYYY This is very important and will be used as a reference point for many questions that follow; this information will be pre-filled; recommend that interviewers calculate relevant dates from this time frame to tailor subsequent questions.
			Patient status	Check the appropriate box for the patient: • Case (i.e., death) • Hospitalized control • Outpatient control
			Interviewer Interview date	Print first and last name of person who conducted interview Date interview was conducted (MM/DD/YYYY); this is the date for a successful interview and not unsuccessful attempts which will get recorded on the Log Sheet
			Information source	Patient (SELF form, i.e., living control) or proxy (Living PT or Deceased PT Forms, i.e., cases or minor/incapacitated control) Use proxy (household member aged ≥18, preferably

				the parent or guardian) only if patient died or if he/she is age <18 years old or if there is an indication that patients are mentally or physically incapacitated to the point of not being able to respond for themselves.
			Proxy name	Name of the proxy as gleaned from the medical record
			Age of patient at the time of the interview	This question is to ascertain minor status. Pre-fill this before interview based on lab data to know when to ask for a proxy. All patients <18, all cases, and possibly other adult controls will need proxies
			INTRODUCTION	
			Read the Purpose and Objectives para	Would you like to go on? If not, better time/number to call?
	12/3/10		Are you the person who knows best about the patient?	Yes or No
			If, Yes, what was your relationship to patient	Relationship to patient
			Did you live with the patient	At the time of illness, did the proxy live with the patient
	12/3/10		If No, who would be a better person to talk to	Instructions should reflect that we are seeking the proxy who is the adult in the house who knows most about the health history of the case patient, or the control. If the person who answers the phone is not that person, ask for the best time and phone number when that person can be reached.
	12/3/10		Relationship	Relationship of the alternate person to the patient
	12/3/10		Telephone #	Telephone # for the alternate contact **END THE INTERVIEW IF ANOTHER PERSON IS SUGGESTED AS A BETTER CONTACT**
			There are approx 30 questions, will take ~15mins	Would you like to go on? If not, better time/number to call?
			At the time of flu illness, what was your (the patient's) town/community and state of residence?	List town/community, state CSTE guidance will be used to ascertain state of residence (http://www.cdc.gov/ncphi/disss/nndss/phs/files/03-ID-10_residency_rules.pdf)
			At the time of flu illness, what was your (the patient's) ZIP code of residence	List zip code **END THE INTERVIEW IF THE STATE OF RESIDENCE IS NOT AS EXPECTED, i.e., they will not meet the study criteria**
			HEALTHCARE USE ACCESS	
1		No	**Do you [does Patient Name]** have one person **you [they]** think of as **your [their]** personal doctor or health care provider?	Select only one box Yes No Don't Know Refused
1a		Yes	If Yes, what is that	Check all boxes that apply

			person's background	Physician (MD, DO), Traditional healer, Nurse Practitioner/Physician Assistant, Naturopath, Chiropractor Specify if Other Don't know Refused
2		Yes	In the 12 months before **you were [Patient Name was]** diagnosed with H1N1 flu, did you (or the patient) see a doctor, nurse or other health professional to get any kind of care? (Select only one answer)	Select only one box ☐ Yes ☐ No, even though he/she needed to get care ☐ No, the patient was healthy. There was no need to get care ☐ Don't know ☐ Refused
2a		No	If Yes, what was the name of the clinic or the healthcare provider where you went?	Blank for the name of a clinic/provider and contact info
3		No	Was there a time in the 12 months before **you were [Patient Name was]** diagnosed with H1N1 flu, when **you [Patient Name]** needed to see a health care provider but could not because of cost?	☐ Yes ☐ No ☐ Don't know ☐ Refused
4		No	Was there a time in the 12 months before **you were [Patient Name was]** diagnosed with H1N1 flu, when **you [Patient Name]** needed to see a health care provider but could not because of how far to travel to a healthcare facility or because it was hard to get a ride? This would be from MM 2008 through MM 2009.	☐ Yes ☐ No ☐ Don't know ☐ Refused
5		Yes	About how many miles is **your [Patient Name's]** home from the place you go for healthcare when you are sick? (Select only one answer)	Select only one correct answer ☐ 0-10 miles ☐ 11-30 miles ☐ 31-50 miles ☐ more than 50 miles ☐ Don't know ☐ Refused
6		Yes	What type of health care facility is it?	(Check all that apply) ☐ Private clinic ☐ Tribal clinic ☐ Urban Indian clinic ☐ Indian Health Service Facility ☐ Other public clinic ☐ Hospital emergency department ☐ Other (specify) ☐ Don't know ☐ Refused
7		No	At the time **you were [Patient Name was]** sick,	☐ Yes→q7a ☐ No→q8 ☐ Don't know→q8 ☐ Refused→q8

			did **you [Patient Name]** have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, including IHS benefits?	
7a		Yes	If "Yes", what type of health coverage did **you [Patient Name]** use to cover costs of medical care? Was it coverage through:	Check all that apply: ☐ Your employer ☐ A family member's employer ☐ A plan that you or someone else buys on your own ☐ Medicare ☐ Medicaid or Medical assistance ☐ The military, CHAMPUS, TriCare, or the VA ☐ Indian Health Service ☐ Other (specify) _____ ☐ Don't know ☐ Refused
8		Yes	Was **[Patient Name]** hospitalized for influenza illness in the 30 days after **[he/she]** tested positive for H1N1 in MM 2009?	Yes or No
8a		No	If yes, list hospital name and location	List out hospital name and location
8b		No	If yes, list dates	List dates person was hospitalized
			Vaccine questions **Ten years and older**	
9		No	In the Fall of 2009, **were you [was Patient Name]** vaccinated to prevent H1N1 flu?	Q9 should only be asked for patients who had onset of illness AFTER Sept 2009 ☐ Yes ☐ No ☐ Don't know ☐ Refused
			Nine years old and younger	
9a		No	How many doses of this vaccine did [**Patient Name]** get?	☐ One ☐ Two ☐ Don't know ☐ Refused ☐ Other_____
			EVERYONE	
10		No	In the Fall of 2009, **were you [was Patient Name]** vaccinated to prevent seasonal flu?	Q10 should only be asked for patients who had onset of illness AFTER Sept 2009 ☐ Yes ☐ No ☐ Don't know ☐ Refused
11		No	**Were you [was Patient Name]** vaccinated to prevent seasonal flu during the 2008 – 2009 flu season? This would have been sometime from September 2008 through	☐ Yes ☐ No ☐ Don't know ☐ Refused

			March 2009?	
			For persons 2 years and older	
12		No	**Have you [Has Patient Name]** ever had a pneumonia shot (brand name: Pneumovax)?	**FOR PERSONS 2 YEARS AND OLDER** ☐ Yes ☐ No ☐ Don't know ☐ Refused
			For persons < 15 years old	
13		No	A vaccine called Prevnar is routinely given to infants and children, usually as a series of 4 shots. Has/did (the patient) ever received the Prevnar vaccine?	**FOR PERSONS < 15 YEARS OLD** ☐ Yes ☐ No ☐ Don't know ☐ Refused
			MEDICAL HISTORY RISK FACTORS	
14		Yes	When **you [Patient Name]** got sick, in what kind of place were **you [was he/she was]** living?	Check only one option
15		No	What was the number of rooms in **your [Patient Name's]** house/apartment, excluding bathrooms and closets at the time **you were [he/she was]** sick?	Write in the ##
16		No	How many people age 18 years or older lived in **your [Patient Name's]** household at the time **you were [he/she was]** sick?	Write in the ##
17		No	How many people younger than age 18 years lived in your (the patient's) household at the time of the flu illness?	Write in the ##
18		No	When **you [Patient Name]** got sick, did **you [he/she]** use a wood-burning stove or fireplace to cook or help heat the house?	☐ Yes ☐ No ☐ Don't know ☐ Refused
19		No	When **you [Patient Name]** got sick, did **you [he/she]** have running (plumbed) water in your house?	☐ Yes ☐ No ☐ Don't know ☐ Refused
20		Yes	In what rooms did **you [Patient Name]** have working sinks for washing up? And how many sinks in total were in those types of rooms?	**Check all that apply and write down numbers in each of the types of rooms** ☐Bathroom ☐Kitchen ☐None ☐ Don't know ☐ Refused

21		No	When **you [Patient Name]** got sick, did **you [he/she]** have working flush toilets in the house/apartment? If there's a honeybucket or outhouse, answer "No".	☐ Yes ☐ No ☐ Don't know ☐ Refused
22		No	Have you (has the patient) smoked at least 100 cigarettes in **your [Patient Name's]** entire life?	**Only for patients older than 7 years** **READ TO RESPONDENT: 5 packs = 100 cigarettes** ☐ Yes ☐ No ☐ Don't know ☐ Refused
23		No	When **you [Patient Name]** got sick, did **you [he/she]** smoke cigarettes every day, some days, or not at all?	☐ Every day ☐ Some days ☐ Not at all ☐ Don't know ☐ Refused
24		No	When **you [Patient Name]** got sick, in a typical week, **were you [was he/she]** exposed to secondhand tobacco smoke at home?	☐ Yes ☐ No ☐ Don't know ☐ Refused
24a		Yes	If yes, how often?	☐ Every day ☐ Some days ☐ Not at all ☐ Don't know ☐ Refused
25		No	When **you [Patient Name]** got sick, in a typical week, **were you [was he/she]** exposed to secondhand tobacco smoke at work?	☐ Yes ☐ No ☐ Don't know ☐ Refused
25a		Yes	If yes, how often?	☐ Every day ☐ Some days ☐ Not at all ☐ Don't know ☐ Refused
26		No	During the 30 days before the flu illness, did **you [Patient Name]** have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?	☐ Yes ☐ No ☐ Don't know ☐ Refused
26a		Yes	If yes, how many days per week or per month did **you [he/she]** have at least one drink of any alcoholic beverage**?**	Check box and give number ☐ _____Days per week ☐ ___ Days in past 30 days ☐ No drinks in past 30 days ☐ Don't know / Not sure ☐ Refused
26b		Yes	During the 30 days before **you [Patient Name]** got sick, on the days when **you [Patient Name]** drank, about how many drinks did **you [he/she]** drink on average? One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one	**NOTE: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.** ☐___ Number of drinks ☐Don't know / Not sure ☐ Refused

			shot of liquor.	
27		No	When **you [Patient Name]** got sick, about how much did **you [he/she]** weigh without shoes?	lbs, kg – Circle one ☐ Don't know ☐ Refused
28		No	When **you [Patient Name]** got sick, about how tall **were you [was he/she]** without shoes?	ft./inches, meters/centimeters – Circle one ☐ Don't know ☐ Refused
			DEMOGRAPHICS	
29		No	Are **you [Patient Name]** Hispanic or Latino?	☐ Yes ☐ No ☐ Don't know / Not sure ☐ Refused
30		Yes	What race or races **do you [does/did Patient Name]** consider **yourself [him/herself]**?	Select all that apply ☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian or Alaska Native→q30a ☐ Other? ☐ Refused
30a		No	If American Indian/Alaska Native, What is your tribe/Native Health Corporation?	List tribe or health corp
31		Yes	What **do you [does/did Patient Name]** consider **your [his/her]** primary race if selecting only one?	If there was more than one response to Q30, the ask Q31 and select only one option ☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other, please specify ☐ Don't know ☐ Refused
32		No	What was your occupation?	At the time of illness, what was the occupation; specify for adult respondents only
33		Yes	What is the highest grade or year of school **you [Patient Name]** completed?	Select only one option ☐ Never attended school or only attended kindergarten ☐ Grades 1 through 8 (Elementary) ☐ Grades 9-11 (Some high school) ☐ Grade 12 or GED (High school graduate) ☐ Attended College but did not graduate: ☐ Graduated from College ☐ Post-graduate training ☐ Don't know ☐ Refused
34		No	In 2009, what was **your [Patient Name's]** annual	Select only one option. ☐ <$10,000

			household income from all sources?	☐ $10,000 < $15,000 ☐ $15,000 < $20,000 ☐ $20,000 < $25,000 ☐ $25,000 < $30,000 ☐ $30,000 < $35,000 ☐ $35,000 < $40,000 ☐ $40,000 < $45,000 ☐ $45,000 < $50,000 ☐ $50,000 < $55,000 ☐ $55,000 < $60,000 ☐ $60,000 < $100,000 ☐ $100,000 < $150,000 ☐ > $150,000 DO NOT READ TO RESPONDENT: ☐ Don't know / Not sure ☐ Refused