Study ID: _____ **For office use only.** Enrollment Date: 20__ / __ / ___
Coordinator Initials: _ _ _
MRN: _____ Self-administered ___ RC-administered ___

Baseline Questionnaire

Please complete this questionnaire to the best of your ability. You may skip any questions that you do not feel comfortable answering. This assessment is for research purposes only and the information provided will not be shared with your healthcare providers.

Please note that confidentiality by email cannot be guaranteed and standard text-messaging rates apply.

First Name _____ Last Name _____

Preferred Name _____ _____

Mailing address _____ City _____ ZIP Code _____

Personal email _____ Work email _____

Home phone _____ Cell phone _____ Work phone _____

Do we have permission to text you at your cell phone number?

❍ Yes ❍ No

What is the best number to reach you?

❍ Home phone ❍ Cell phone ❍ Work phone

What is the best time to reach you by phone?

☐ Morning (___: ___AM)| ☐ Afternoon (___: ___PM)| ☐ Evening (___: ___PM)

What is the earliest and latest we could call you?

_____ AM _____PM

Alternate Contact #1 (First and Last Name) _____ Phone number _____

Relationship _____

Alternate Contact #2 (First and Last Name) _____ Phone number _____

Relationship _____

What is your date of birth? _____ / _____ / _____
Month Day Year

What is your sex? ❍ Male ❍ Female

Do you identify your gender as being the same as your sex? ❍ Yes ❍ No, please specify: _____

Do you think of yourself as (select one) :

❍ Lesbian, gay or homosexual
❍ Straight or heterosexual
❍ Bisexual
❍ Something else, please specify: _____
❍ Don't know

The study team is interested in understanding if people with different traits (such as gender, race, or ethnicity, age, weight, etc.) experience equal care. Do you feel that you have the same opportunities to be as healthy as others?

❍ Yes ❍ No

If no, Please tell us why you feel this way:

_____

_____

_____

What is the zip code of your residence? _____

Are you of Hispanic, Latino, or Spanish origin? *For example Mexican, Mexican American, Puerto Rican, Cuban, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.*

❍ Yes, please specify your origin: _____ ❍ No

What is your race/origin? *Please check all racial categories that apply and write in your specific origin(s) in the space on the right*

RACE	ORIGIN
☐ White	*for example, German, Irish, Lebanese, Egyptian, Mexican, etc.*
☐ Black or African American	*for example, African America, Haitian, Nigerian, etc.*
☐ American Indian or Alaska Native	*Write name(s) of enrolled or principal tribe(s): Navajo, Mayan, Tlingit, etc.*
☐ Asian	*for example, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Hmong, Laotion, Thai, Pakistani, Cambodian, etc.*
☐ Native Hawaiian or Other Pacific Islander	*for example, Native Hawaiian, Guamanian or Chamorro, Samoan, Fijian, Tongan, etc.*
☐ Some other race, *please specify:* _____	Write origin(s):

Is English the primary language spoken in your household?

❍ Yes

❍ No, the primary language is Spanish

❍ No, the primary language is: _____

What is your current marital status?

❍ Married
❍ Divorced
❍ Widowed

❍ Separated
❍ Single, never married
❍ Unmarried, living with partner

What is the highest education level that you have attained?

❍ Less than high school
❍ High school graduate or GED
❍ Some college, no degree
❍ Occupational/technical/vocational program
❍ Associate degree: academic program
❍ Bachelor's degree
❍ Master's degree (e.g. M.A., M.S., M. Eng., M. Eng., M.B.A)
❍ Professional school degree (e.g. M.D., D.D.S., D.V.M., J.D.)
❍ Doctoral degree (e.g. Ph.D., Ed.D.)

What is the primary source of your health care coverage? *(Check one)*

❍ A plan purchased through an employer or union, including a plan purchased through a family member/partner's employer/union
❍ A plan that you or another family member buys on your own
❍ Medicare
❍ Medicaid or other state program
❍ TRICARE (formerly CHAMPUS), VA, or Military
❍ Alaska Native, Indian Health Service, Tribal Health Services
❍ Some other source
❍ None (no coverage)

If you were admitted or readmitted to the hospital for your appendicitis, would you be worried about the bills you would have to pay out of pocket?

❍ Yes ❍ No

What is your current employment status? *(Check one)*

❍ Employed, full-time
❍ Employed, part-time
❍ Employed, but on sick leave or maternity leave
❍ Unemployed, looking for work
❍ Unemployed, NOT looking for work
❍ Disabled
❍ Student
❍ Retired
❍ Other, specify: _____

If employed, do you work outside of the home?

❍ Yes ❍ No ❍ Not employedIf employed, how often does your job require a lot of physical activity during your work shift? *(Check one)*

❍ All of the time
❍ Most of the time

❍ Some of the time
❍ A little of the time
❍ Never
❍ Not employed

How many people are currently living in your household, including yourself?

_____ Number of people

_____ Of these people, how many are children (individuals under 18 years of age)?

_____ Of these people, how many are adults?

_____ Of the adults, how many bring income into the household?Which of these categories best describes your total combined family income for the past 12 months? *(Check one)*

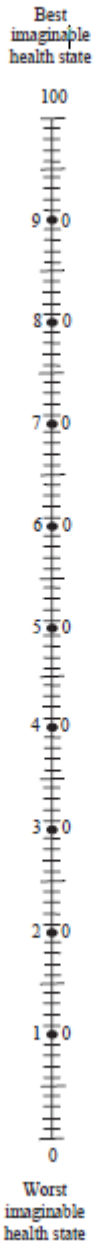
This should include your total combined family income (before taxes) from all sources, wages, rent from properties, social security, disability and/or veteran's benefits, unemployment benefits, workman's compensation, help from relatives (including child payments and alimony), and so on.

❍ Less than $5,000
❍ $5,000 through $11,999
❍ $12,000 through $15,999
❍ $16,000 through $24,999
❍ $25,000 through $34,999
❍ $35,000 through $49,999
❍ $50,000 through $74,999
❍ $75,000 through $99,999
❍ $100,000 and greater
❍ Prefer not to answer

By placing a checkmark in one box in each group below, Please indicate which statements best describe your own health state today.

Mobility	
I have no problems in walking about	☐
I have some problems in walking about	☐
I am confined to bed	☐
Self-Care	
I have no problems with self-care	☐
I have some problems washing or dressing myself	☐
I am unable to wash or dress myself	☐
Usual Activities (e.g. work, study, housework, family or leisure activities)	
I have no problems with performing my usual activities	☐
I have some problems with performing my usual activities	☐
I am unable to perform my usual activities	☐

Pain/Discomfort	
I have no pain or discomfort	☐
I have moderate pain or discomfort	☐
I have extreme pain or discomfort	☐
Anxiety/Depression	
I am not anxious or depressed	☐
I am moderately anxious or depressed	☐
I am extremely anxious or depressed	☐

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.	**Your own health state today** 

Please respond to each item by marking one response per row.

	Excellent	Very good	Good	Fair	Poor

In general, would you say your health is:	☐	☐	☐	☐	☐
In general, would you say your quality of life is:	☐	☐	☐	☐	☐
In general, how would you rate your physical health?	☐	☐	☐	☐	☐
In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐	☐	☐	☐	☐
	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐	☐	☐	☐	☐
	Never	Rarely	Sometimes	Often	Always
In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐	☐	☐	☐	☐
	None	Mild	Moderate	Severe	Very Severe
In the past 7 days, how would you rate your fatigue on average?	☐	☐	☐	☐	☐

	0 (No pain)	1	2	3	4	5	6	7	8	9	10 (Worst imagin-able pain)
In the past 7 days, how would you rate your pain on average?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please respond to each item by marking one response per row.

	Had no pain	Mild	Moderate	Severe	Very Severe
In the past 7 days, how intense was your pain at its worst?	☐	☐	☐	☐	☐
In the past 7 days, how intense was your average pain?	☐	☐	☐	☐	☐

	No Pain	Mild	Moderate	Severe	Very Severe
What is your level of pain right now?	☐	☐	☐	☐	☐

Before coming to the hospital today, did you have any of the following symptoms?

	Yes	No
Fever or shaking chills	☐	☐
Nausea or vomiting	☐	☐
No hunger/appetite	☐	☐
Belly pain	☐	☐
Diarrhea	☐	☐

When do you think you started getting sick with appendicitis?

Date: _____ / _____ / _____ Approximate time: _____: ____ ☐ AM ☐ PM
Month Day Year Hour Minutes *(Check one)*

How many family members and/or friends depend on you to help them on a regular basis?

❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5+ Please describe the family members and/or friends who depend on you. *Please check all that apply.*

❍ Children under age 5
❍ Children age 5-18
❍ Older/elder adults
❍ Persons with disabilities
❍ Family members or friends with a medical condition

Is there at least one other adult sharing those responsibilities with you?

❍ Yes ❍ No

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from you doctor or pharmacy? *(Check one)*

❍ Never ❍ Rarely ❍ Sometimes ❍ Often ❍ Always

In general, thinking back before your appendicitis…

	Never	Rarely	Sometimes	Usually	Always
Do you have someone to take you to the doctor if you need it?	☐	☐	☐	☐	☐
Do you have someone to run errands if you need it?	☐	☐	☐	☐	☐

Do you have someone to help with your daily chores if you are sick?	☐	☐	☐	☐	☐
Do you have someone to help you if you are confined to a bed?	☐	☐	☐	☐	☐

Please indicate how successful you believe each treatment option could be in treating your appendicitis by choosing a number on a scale of 0-10, with '0' being unsuccessful, '5' being unsure, and '10' being a completely successful treatment of appendicitis.

CIRCLE A NUMBER

Antibiotics could not treat my appendicitis. — 0 1 2 3 4 5 6 7 8 9 10 — Antibiotics could treat my appendicitis.

Unsuccessful — Unsure — Completely successful

CIRCLE A NUMBER

Surgery could not treat my appendicitis. — 0 1 2 3 4 5 6 7 8 9 10 — Surgery could treat my appendicitis.

Unsuccessful — Unsure — Completely successful

Do you expect that in 1 month you will be back to feeling like your usual self before you had your appendicitis attack?

❍ Yes ❍ No

Please indicate how safe you believe each treatment option could be in treating your appendicitis by choosing a number on a scale of 0-10, with '0' being unsafe, '5' being unsure, and '10' being a completely safe treatment of appendicitis.

CIRCLE A NUMBER

Antibiotics could not safely treat my appendicitis. 0 1 2 3 4 5 6 7 8 9 10 Antibiotics could safely treat my appendicitis.

(Unsafe) (Unsure) (Completely safe)

CIRCLE A NUMBER

Surgery could not safely treat my appendicitis. 0 1 2 3 4 5 6 7 8 9 10 Surgery could safely treat my appendicitis.

(Unsafe) (Unsure) (Completely safe)

In general, thinking back before your appendicitis, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain:

When I'm in pain…..	Not at all	To a slight degree	To a moderate degree	To a great degree	All of the time
I worry all the time about whether the pain will end.	☐	☐	☐	☐	☐
I feel I can't go on.	☐	☐	☐	☐	☐
It's terrible and I think it's never going to get any better.	☐	☐	☐	☐	☐
It's awful and I feel that it overwhelms me.	☐	☐	☐	☐	☐
I feel I can't stand it anymore.	☐	☐	☐	☐	☐
I become afraid that the pain will get worse.	☐	☐	☐	☐	☐
I keep thinking of other painful events.	☐	☐	☐	☐	☐
I anxiously want the pain to go away.	☐	☐	☐	☐	☐
I can't seem to keep it out of my mind.	☐	☐	☐	☐	☐

I keep thinking about how much it hurts.	☐	☐	☐	☐	☐
I keep thinking about how badly I want the pain to stop.	☐	☐	☐	☐	☐
There's nothing I can do to reduce the intensity of the pain.	☐	☐	☐	☐	☐
I wonder whether something serious may happen.	☐	☐	☐	☐	☐

In general, please tell us how much you agree with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Sometimes doctors care more about what is convenient for them than about their patients' medical needs.	☐	☐	☐	☐	☐
Doctors are extremely thorough and careful.	☐	☐	☐	☐	☐
You completely trust doctors' decisions about which medical treatments are best.	☐	☐	☐	☐	☐
A doctor would never mislead you about anything.	☐	☐	☐	☐	☐
All in all, you trust doctors completely.	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Usually	Always
I have someone who will listen to me when I need to talk.	☐	☐	☐	☐	☐
I have someone to confide in or talk to about myself of my problems.	☐	☐	☐	☐	☐
I have someone who makes me feel appreciated.	☐	☐	☐	☐	☐
I have someone to talk with when I have a bad day.	☐	☐	☐	☐	☐