

Section M7 — OTHER DEVICE PAGE

CHECK ITEM 17	Enter name, person number and device from "OTHER" column of Table MDI.	Name _____ 3-4 Person No. _____ 5-6 _____ 7-8 MDI
CHECK ITEM 18	Refer to "MDI" in Check Item 17.	1 <input type="checkbox"/> Infusion pump (1) 9 2 <input type="checkbox"/> Some other device (2)
These next questions are about your infusion pump. 1 a. Is the infusion pump for chemotherapy, insulin treatment, or something else?		1 <input type="checkbox"/> Chemotherapy 10 2 <input type="checkbox"/> Insulin 3 <input type="checkbox"/> Other — Specify <input checked="" type="checkbox"/>
b. Is the pump itself implanted inside your body, or is the pump worn on the outside?		1 <input type="checkbox"/> Inside 11 2 <input type="checkbox"/> Outside
(These next questions are about your <u>entry in CHECK ITEM 17</u> .) 2a. In what part of the body is the (other) <u>entry in CHECK ITEM 17</u> located?		1. _____ 12-14 2. _____ 15-17 3. _____ 18-20
b. Do you have any other <u>entry in CHECK ITEM 17</u>?		1 <input type="checkbox"/> Yes (Reask 2a and b) 21 2 <input type="checkbox"/> No
CHECK ITEM 19	Enter each body part in a separate column as well as name and person number and MDI type in Check Item 17.	_____ 22-24 Body part
3a. Is the <u>entry in CHECK ITEM 17</u> in your <u>entry in CHECK ITEM 19</u> a replacement for a previous one?		1 <input type="checkbox"/> Yes 25 2 <input type="checkbox"/> No (4)
b. How many times has the <u>entry in CHECK ITEM 17</u> in your <u>entry in CHECK ITEM 19</u> been replaced?		_____ Times 26-27
c. Why did you have the <u>entry in Check Item 17/19</u> replaced (the LAST time)? Mark first three mentioned.		00 <input type="checkbox"/> Normal growth 28-29 01 <input type="checkbox"/> Infection 30-31 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 32 02 <input type="checkbox"/> Defect or malfunction 33-34 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 35 03 <input type="checkbox"/> Healing problem 36-37 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 38 04 <input type="checkbox"/> Pain 39-40 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 41 05 <input type="checkbox"/> Blood clots 42-43 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 44 06 <input type="checkbox"/> Bleeding 45-46 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 47 07 <input type="checkbox"/> Injury 48-49 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 50 88 <input type="checkbox"/> Some other reason — Specify <input checked="" type="checkbox"/> 51-52 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days 53
d. How long had you had that <u>entry in CHECK ITEM 17</u> when the <u>entry in 3c</u> was first noticed? Was it less than 30 days, 30 to 90 days, or more than 90 days?		

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<p>3e. How long did you have the (entry in CHECK ITEM 17/19) before it was replaced with the one you have NOW?</p>	<p>97 <input type="checkbox"/> Less than 6 months 98 <input type="checkbox"/> 6-11 months _____ Years</p>	<p>54-55</p>
<p>f. In what month and year did you get it?</p>	<p>_____/19_____ Month Year 0000 <input type="checkbox"/> Before 1968 9898 <input type="checkbox"/> 1968 or later</p>	<p>56-59</p>
<p>4a. How long have you had the (entry in CHECK ITEM 17/19) you have NOW?</p>	<p>97 <input type="checkbox"/> Less than 6 months 98 <input type="checkbox"/> 6-11 months _____ Years</p>	<p>60-61</p>
<p>b. In what month and year did you get this one?</p>	<p>_____/19_____ Month Year 0000 <input type="checkbox"/> Before 1968 9898 <input type="checkbox"/> 1968 or later</p>	<p>62-65</p>
<p>Please tell me if you have had any of the following problems or complications with or as a result of the (entry in CHECK ITEM 17) you NOW have in your (entry in CHECK ITEM 19)?</p>		<p>66</p>
<p>5a. Have you had an infection?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (5c) 9 <input type="checkbox"/> DK }</p>	
<p>b. How long had you had your (entry in CHECK ITEM 17/19) when the infection was first noticed? Was it less than 30 days, 30 to 90 days, or more than 90 days?</p>	<p>1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>67</p>
<p>c. Have you had any healing problems (with the (entry in CHECK ITEM 17/19) you have NOW)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (5e) 9 <input type="checkbox"/> DK }</p>	<p>68</p>
<p>d. How long had you had your (entry in CHECK ITEM 17/19) when the healing problem was first noticed? Was it less than 30 days, 30 to 90 days, or more than 90 days?</p>	<p>1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>69</p>
<p>e. Other than discomfort generally associated with surgery and healing, have you had any other pain (with the (entry in CHECK ITEM 17/19) you have NOW)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (5g) 9 <input type="checkbox"/> DK }</p>	<p>70</p>
<p>f. How long had you had your (entry in CHECK ITEM 17/19) when the pain was first noticed? Was it less than 30 days, 30 to 90 days, or more than 90 days?</p>	<p>1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>71</p>
<p>g. Have you had any defects with the (entry in CHECK ITEM 17/19) you have NOW or has it failed to operate properly?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (5i) 9 <input type="checkbox"/> DK }</p>	<p>72</p>
<p>h. How long had you had your (entry in CHECK ITEM 17/19) when this problem was first noticed? Was it less than 30 days, 30 to 90 days, or more than 90 days?</p>	<p>1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>73</p>
<p>i. Have you had any other problems or complications with or as a result of the (entry in CHECK ITEM 17/19) you have NOW?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (6) 9 <input type="checkbox"/> DK }</p>	<p>74</p>
<p>j. What were they?</p> <p><i>Record first three mentioned</i></p> <p><i>Ask for each entry in 5j</i></p>	<p>01 _____ 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>75-76</p>
<p>k. How long had you had the (entry in CHECK ITEM 17/19) when the (problem in 5j) was first noticed? Was it less than 30 days, 30 to 90 days, or more than 90 days?</p>	<p>02 _____ 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>77</p>
	<p>03 _____ 1 <input type="checkbox"/> Less than 30 days 2 <input type="checkbox"/> 30-90 days 3 <input type="checkbox"/> More than 90 days</p>	<p>78-79</p>
		<p>80</p>
		<p>81-82</p>
		<p>83</p>

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6. Why did you need to get the (entry in CHECK ITEM 17/19) in the first place?

Mark all mentioned

01 Infection

84-85

02 Injury

86-87

88 Some other reason – Specify ∇

88-89

CHECK ITEM 20

Mark appropriate respondent box and enter relationship to MDI person if proxy.

1 Self—personal

90

2 Self—telephone

3 Proxy —personal

4 Proxy — telephone

} Relationship

Go to next column or next device

91-92

Notes