



Appendix III Questionnaires and flashcards

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FORM **HIS-1 (1994)**
18-2-93

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

NATIONAL HEALTH INTERVIEW SURVEY

1. Book ___ of ___ books

2. R.O. number

3. Sample

4. Segment type
 Area Permit Block

5. Control number
PSU | Segment | Serial

6a. What is your exact address? (Include House No., Apt. No., or other identification; county and ZIP Code)

City _____ State _____ County _____ ZIP Code _____

b. Is this your mailing address? (Mark box or specify if different. Same as 6a. Include county and ZIP Code.)

City _____ State _____ County _____ ZIP Code _____

c. Special place name _____ Sample unit number _____ Type code _____

7. YEAR BUILT
 Ask
 Do not ask

When was this structure originally built?
 Before 4-1-80 (Continue interview)
 After 4-1-80 (Complete item 8c when required; end interview)

8. COVERAGE QUESTIONS
 Ask items that are marked
 Do not ask

a. Are there any occupied or vacant living quarters besides your own in this building? Yes (Fill Table X) No

b. Are there any occupied or vacant living quarters besides your own on this floor? Yes (Fill Table X) No

c. Is there any other building on this property for people to live in, either occupied or vacant? Yes (Fill Table X) No

9a. LAND USE
1 URBAN (10)
2 RURAL
— Reg. units and SP. PL. units coded 85—88 in 6c — Ask item 9b
— SP. PL. units not coded 85—88 in 6c — Mark "No" in item 9b without asking

b. During the past 12 months did sales of crops, livestock, and other farm products from this place amount to \$1,000 or more?
1 Yes } (10)
2 No }

10. CLASSIFICATION OF LIVING QUARTERS — Mark by observation

a. LOCATION of unit
Unit is:
 In a Special Place — Refer to Table A in Part C of manual; then complete 10c or d
 NOT in a Special Place (10b)

b. Access
 Direct (10c)
 Through another unit — Not a separate HU; combine with unit through which access is gained. (Apply merged unit procedures if additional living quarters space was listed separately.)

c. HOUSING unit (Mark one, THEN page 2)
01 House, apartment, flat
02 HU in nontransient hotel, motel, etc.
03 HU-permanent in transient hotel, motel, etc.
04 HU in rooming house
05 Mobile home or trailer with no permanent room added
06 Mobile home or trailer with one or more permanent rooms added
07 HU not specified above — Describe in footnotes

d. OTHER unit (Mark one)
08 Quarters not HU in rooming or boarding house
09 Unit not permanent in transient hotel, motel, etc.
10 Unoccupied site for mobile home, trailer, or tent
11 Student quarters in college dormitory
12 OTHER unit not specified above — Describe in footnotes

11a. What is the telephone number here? Area code/number _____
 None

b. Is there any working telephone located INSIDE your home?
1 Yes 2 No

12. Interview observed?
1 Yes 2 No

13a. Field representative's name _____ Code _____

b. Language of interview
1 English 3 Both English and Spanish
2 Spanish 8 Other

14. Noninterview reason

TYPE A
01 Refusal — Describe in footnotes
02 No one at home, repeated calls
03 Temporarily absent — Footnote
04 Other (Specify) _____

TYPE B
06 Vacant — nonseasonal
07 Vacant — seasonal
08 Occupied entirely by persons with URE members
09 Unfit or to be demolished
10 Under construction, not ready
11 Converted to temporary business or storage
12 Unoccupied site for mobile home, trailer, or tent
13 Permit granted, construction not started
14 Other (Specify) _____

TYPE C
15 Unused line of listing sheet
16 Demolished
17 House or trailer moved
18 Outside segment
19 Converted to permanent business or storage
20 Merged
21 Condemned
22 Built after April 1, 1980
23 Other (Specify) _____

15. Record of calls

| Month | Date | Beginning time | Ending time | Completed Mark (X) |
|-------|------|----------------|--------------|--------------------|
| 1 | | P T | a.m. p.m. | |
| 2 | | P T | a.m. p.m. | |
| 3 | | P T | a.m. p.m. | |
| 4 | | P T | a.m. p.m. | |
| 5 | | P T | a.m. p.m. | |
| 6 | | P T | a.m. p.m. | |

16. List column numbers of persons requiring callbacks, and indicate reason(s).
 None

| Person No. | S.S. No. | Other | Person No. | S.S. No. | Other |
|------------|----------|-------|------------|----------|-------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

17. Record of additional contacts

| Month | Date | Beginning time | Ending time | Completed Person No. |
|-------|------|----------------|--------------|----------------------|
| 1 | | P T | a.m. p.m. | |
| 2 | | P T | a.m. p.m. | |
| 3 | | P T | a.m. p.m. | |
| 4 | | P T | a.m. p.m. | |

GO TO HOUSEHOLD COMPOSITION PAGE

A. HOUSEHOLD COMPOSITION PAGE

1

1 a. What are the names of all persons living or staying here? Start with the name of the person or one of the persons who owns or rents this home. Enter name in REFERENCE PERSON column.

b. What are the names of all other persons living or staying here? Enter names in columns.

c. I have listed (read names). Have I missed:

- any babies or small children?
- any lodgers, boarders, or persons you employ who live here?
- anyone who USUALLY lives here but is now away from home traveling or in a hospital?
- anyone else staying here?

d. Do all of the persons you have named usually live here? Yes (2) No (APPLY HOUSEHOLD MEMBERSHIP RULES. Delete nonhousehold members by an "X" from 1-C2 and enter reason.)

Probe if necessary:
Does -- usually live somewhere else?

| | |
|----------------------------------|--------------------------|
| If "Yes," enter names in columns | |
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

1. First name _____ Mid. init. _____ Age _____
Last name _____ Sex M F

2. Relationship REFERENCE PERSON _____

3. Date of birth Month _____ Date _____ Year _____

| | | | |
|----------------------------------|-------------------------------|--------------------------------|----------------------------------|
| HOSP. | WORK | RD | 2-WK. DV |
| 00 <input type="checkbox"/> None | 1 <input type="checkbox"/> Wa | 1 <input type="checkbox"/> Yes | 00 <input type="checkbox"/> None |
| Number | 2 <input type="checkbox"/> Wb | 2 <input type="checkbox"/> No | Number |

Ask for all persons beginning with column 2:

2. What is -- relationship to (reference person)?

3. What is -- date of birth? (Enter date and age and mark sex.)

| | |
|--------------------------|------------------------------|
| REFERENCE PERIODS | |
| A1 | 2-WEEK PERIOD _____ |
| | 12-MONTH DATE _____ |
| | 13-MONTH HOSPITAL DATE _____ |
| A2 | ASK CONDITION LIST _____ |

C1

| | | | | | | | |
|----|-----|----|------|----|------|-----|-------|
| LA | IRA | DV | TINJ | CL | LTRI | HST | COND. |
| | | | | | | | |

C2

| | | | | | | | |
|----|-----|----|------|----|------|-----|-------|
| LA | IRA | DV | TINJ | CL | LTRI | HST | COND. |
| | | | | | | | |

C3

| | | | | | | | |
|----|-----|----|------|----|------|-----|-------|
| LA | IRA | DV | TINJ | CL | LTRI | HST | COND. |
| | | | | | | | |

A3 Refer to ages of all related HH members.

A3 All persons 65 and over (5) Other (4a)

4a. Are any of the persons in this family now on full-time active duty with the armed forces? Yes No (5)

b. Who is this? Delete column number(s) _____ by an "X" from 1-C2.

c. Anyone else? Yes (Reask 4b and c) No

Ask for each person in armed forces:

d. Where does -- usually live and sleep, here or somewhere else? Mark box in person's column.

4d. Living at home Not living at home

If related persons 17 and over are listed in addition to the respondent and are not present, say:

5. We would like to have all adult family members who are at home take part in the interview. Are (names of persons 17 and over) at home now? If "Yes," ask: Could they join us? (Allow time)

Read to respondent(s):
This survey is being conducted to collect information on the nation's health. I will ask about hospitalizations, disability, visits to doctors, illness in the family, and other health related items.

HOSPITAL PROBE

6a. Since (13-month hospital date) a year ago, was -- a patient in a hospital OVERNIGHT?

b. How many different times did -- stay in any hospital overnight or longer since (13-month hospital date) a year ago?

6a. 1 Yes (6b) 2 No (Mark "HOSP." box, THEN NP)

b. _____ } (Make entry in "HOSP." box THEN NP)
Number of times

Ask for each child under one:

7a. Was -- born in a hospital?

Ask for mother and child:

b. Have you included this hospitalization in the number you gave me for --?

7a. 1 Yes (7b) 2 No (NP)

b. Yes (NP) No (Correct 6 and "HOSP." box)

FOOTNOTES

B. LIMITATION OF ACTIVITIES PAGE

| | | | |
|------------|--|------------|---|
| B1 | Refer to age. | B1 | 1 <input type="checkbox"/> 18-69(1) 2 <input type="checkbox"/> Other (NP) |
| 1. | What was -- doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? <i>Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.</i> | 1. | 1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5) |
| 2a. | Does any impairment or health problem NOW keep -- from working at a job or business? | 2a. | 1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No |
| b. | Is -- limited in the kind OR amount of work -- can do because of any impairment or health problem? | b. | 2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (6) |
| 3a. | Does any impairment or health problem NOW keep -- from doing any housework at all? | 3a. | 4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No |
| b. | Is -- limited in the kind OR amount of housework -- can do because of any impairment or health problem? | b. | 5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5) |
| 4a. | What (other) condition causes this? <i>Ask if injury or operation: When did [the (injury) occur?/ -- have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 3 where limitation reported, saying: Except for -- (condition), ...? OR reask 4b/c.</i> | 4a. | (Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c) |
| b. | Besides (condition) is there any other condition that causes this limitation? | b. | <input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d) |
| c. | Is this limitation caused by any (other) specific condition? | c. | <input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No |
| d. | Which of these conditions would you say is the MAIN cause of this limitation? | d. | <input type="checkbox"/> Only 1 condition Main cause _____ |
| 5a. | Does any impairment or health problem keep -- from working at a job or business? | 5a. | 1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No |
| b. | Is -- limited in the kind OR amount of work -- could do because of any impairment or health problem? | b. | 2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No |
| B2 | Refer to questions 3a and 3b. | B2 | 1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6) |
| 6a. | Is -- limited in ANY WAY in any activities because of an impairment or health problem? | 6a. | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) |
| b. | In what way is -- limited? <i>Record limitation, not condition.</i> | b. | Limitation _____ |
| 7a. | What (other) condition causes this? <i>Ask if injury or operation: When did [the (injury) occur?/ -- have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 2, 5, or 6 where limitation reported, saying: Except for -- (condition), ...? OR reask 7b/c.</i> | 7a. | (Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c) |
| b. | Besides (condition) is there any other condition that causes this limitation? | b. | <input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d) |
| c. | Is this limitation caused by any (other) specific condition? | c. | <input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No |
| d. | Which of these conditions would you say is the MAIN cause of this limitation? | d. | <input type="checkbox"/> Only 1 condition Main cause _____ |

| B. LIMITATION OF ACTIVITIES PAGE, Continued | | | |
|--|--|-------------|---|
| B3 | Refer to age. | B3 | 0 <input type="checkbox"/> Under 5 (10) 2 <input type="checkbox"/> 18-69 (NP) 1 <input type="checkbox"/> 5-17 (11) 3 <input type="checkbox"/> 70 and over (8) |
| | 8. What was — doing MOST OF THE PAST 12 MONTHS; working at a job or business, keeping house, going to school, or something else? <i>Priority if 2 or more activities reported: (1) Spent the most time doing; (2) Considers the most important.</i> | 8. | 1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house 3 <input type="checkbox"/> Going to school 4 <input type="checkbox"/> Something else |
| | 9a. Because of any impairment or health problem, does — need the help of other persons with — personal care needs, such as eating, bathing, dressing, or getting around this home? | 9a. | 1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No |
| | b. Because of any impairment or health problem, does — need the help of other persons in handling — routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? | b. | 2 <input type="checkbox"/> Yes (13) 3 <input type="checkbox"/> No (12) |
| | 10a. Is — able to take part AT ALL in the usual kinds of play activities done by most children — age? | 10a. | <input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13) |
| | b. Is — limited in the kind OR amount of play activities — can do because of any impairment or health problem? | b. | 1 <input type="checkbox"/> Yes (13) 2 <input type="checkbox"/> No (12) |
| | 11a. Does any impairment or health problem NOW keep — from attending school? | 11a. | 1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No |
| | b. Does — attend a special school or special classes because of any impairment or health problem? | b. | 2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No |
| | c. Does — need to attend a special school or special classes because of any impairment or health problem? | c. | 3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No |
| | d. Is — limited in school attendance because of — health? | d. | 4 <input type="checkbox"/> Yes (13) 5 <input type="checkbox"/> No |
| | 12a. Is — limited in ANY WAY in any activities because of an impairment or health problem? | 12a. | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP) |
| | b. In what way is — limited? <i>Record limitation, not condition.</i> | b. | _____ Limitation |
| | 13a. What (other) condition causes this? <i>Ask if injury or operation: When did [the (injury) occur?]/— have the operation?</i> <i>Ask if operation over 3 months ago: For what condition did — have the operation?</i> <i>If pregnancy/delivery or 0-3 months injury or operation —</i> <i>Reask question where limitation reported, saying: Except for — (condition), ...?</i> <i>OR reask 13b/c.</i> | 13a. | (Enter condition in C2, THEN 13b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c) |
| | b. Besides (condition) is there any other condition that causes this limitation? | b. | <input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d) |
| | c. Is this limitation caused by any (other) specific condition? | c. | <input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No |
| | d. Which of these conditions would you say is the MAIN cause of this limitation? <i>Mark box if only one condition.</i> | d. | <input type="checkbox"/> Only 1 condition _____ Main cause |
| FOOTNOTES | | | |

D. RESTRICTED ACTIVITY PAGE PERSON 1

Hand calendar.

{The next questions refer to the 2 weeks outlined in red on that calendar, beginning Monday, (date) and ending this past Sunday (date).}

D1

Refer to age.

- Under 5 (4) 5-17 (3) 18 and over (1)

1 a. DURING THOSE 2 WEEKS, did -- work at any time at a job or business not counting work around the house? (Include unpaid work in the family [farm/business].)

- 1 Yes (Mark "Wa" box, THEN 2) 2 No

b. Even though -- did not work during those 2 weeks, did -- have a job or business?

- 1 Yes (Mark "Wb" box, THEN 2) 2 No (4)

2 a. During those 2 weeks, did -- miss any time from a job or business because of illness or injury?

- Yes oo No (4)

b. During that 2-week period, how many days did -- miss more than half of the day from -- job or business because of illness or injury?

- oo None (4) (4)

3 a. During those 2 weeks, did -- miss any time from school because of illness or injury?

- Yes oo No (4)

b. During that 2-week period, how many days did -- miss more than half of the day from school because of illness or injury?

- oo None

4 a. During those 2 weeks, did -- stay in bed because of illness or injury?

- Yes oo No (6)

b. During that 2-week period, how many days did -- stay in bed more than half of the day because of illness or injury?

- oo None (6) (D2)

D2

Refer to 2b and 3b.

- No days in 2b or 3b (6)
 1 or more days in 2b or 3b (5)

5. On how many of the (number in 2b or 3b) days missed from [work/school] did -- stay in bed more than half of the day because of illness or injury?

- oo None

Refer to 2b, 3b, and 4b.

6 a. (Not counting the day(s) [missed from work missed from school (and) in bed]),

Was there any (OTHER) time during those 2 weeks that -- cut down on the things -- usually does because of illness or injury?

- Yes oo No (D3)

b. (Again, not counting the day(s) [missed from work missed from school (and) in bed]),

During that period, how many (OTHER) days did -- cut down for more than half of the day because of illness or injury?

- oo None

D3

Refer to 2-6.

- No days in 2-6 (Mark "No" in RD, THEN NP)
 1 or more days in 2-6 (Mark "Yes" in RD, THEN 7)

Refer to 2b, 3b, 4b, and 6b.

7 a. What (other) condition caused -- to [miss work miss school (or) stay in bed (or) cut down] during those 2 weeks?

(Enter condition in C2, THEN 7b)

b. Did any other condition cause -- to [miss work miss school (or) stay in bed (or) cut down] during that period?

- 1 Yes (Reask 7a and b) 2 No

FOOTNOTES

E. 2-WEEK DOCTOR VISITS PROBE PAGE

Read to respondent(s):

These next questions are about health care received during the 2 weeks outlined in red on that calendar.

E1 Refer to age.

E1 Under 14 (1b)
 14 and over (1a)

1 a. During those 2 weeks, how many times did — see or talk to a medical doctor? { Include all types of doctors, such as dermatologists, psychiatrists, and ophthalmologists, as well as general practitioners and osteopaths. } (Do not count times while an overnight patient in a hospital.)

1 a. and b. 00 None
 } (NP)
 Number of times

b. During those 2 weeks, how many times did anyone see or talk to a medical doctor about — ? (Do not count times while an overnight patient in a hospital.)

2 a. (Besides the time(s) you just told me about) During those 2 weeks, did anyone in the family receive health care at home or go to a doctor's office, clinic, hospital or some other place? Include care from a nurse or anyone working with or for a medical doctor. Do not count times while an overnight patient in a hospital. Yes No (3a)

b. Who received this care? Mark "DR Visit" box in person's column.

2 b. DR Visit

c. Anyone else? Yes (Reask 2b and c) No

Ask for each person with "DR Visit" in 2b:

d. How many times did — receive this care during that period?

d.
Number of times

3 a. (Besides the time(s) you already told me about) During those 2 weeks, did anyone in the family get any medical advice, prescriptions or test results over the PHONE from a doctor, nurse, or anyone working with or for a medical doctor? Yes No (E2)

b. Who was the phone call about? Mark "Phone call" box in person's column.

3 b. Phone call

c. Were there any calls about anyone else? Yes (Reask 3b and c) No

Ask for each person with "Phone call" in 3b:

d. How many telephone calls were made about — ?

d.
Number of calls

E2 Add numbers in 1, 2d, and 3d for each person. Record total number of visits and calls in "2-WK. DV" box in item C1.

FOOTNOTES

F. 2-WEEK DOCTOR VISITS PAGE

DR VISIT 1

Refer to C1, "2-WK. DV" box.

PERSON NUMBER _____

F1 Refer to age.

F1 Under 14 (1b)
 14 and over (1a)

1 a. On what (other) date(s) during those 2 weeks did -- see or talk to a medical doctor, nurse, or doctor's assistant?
b. On what (other) date(s) during those 2 weeks did anyone see or talk to a medical doctor, nurse, or doctor's assistant about --?
Ask after last DR visit column for this person:
c. Were there any other visits or calls for -- during that period? Make necessary correction to 2-Wk. DV box in C1.

1 a. and b. Month _____ Date _____ OR 7777 Last week
 8888 Week before
c. 1 Yes (Reask 1a or b and c)
2 No (Ask 2-6 for each visit)

2. Where did -- receive health care on (date in 1), at a doctor's office, clinic, hospital, some other place, or was this a telephone call?
If doctor's office: Was this office in a hospital?
If hospital: Was it the outpatient clinic or the emergency room?
If clinic: Was it a hospital outpatient clinic, a company clinic, a public health clinic, or some other kind of clinic?
If lab: Was this lab in a hospital?
What was done during this visit? (Footnote)

2. 01 Telephone
Not in hospital: 02 Home 03 Doctor's office 04 Co. or Ind. clinic 05 Other clinic 06 Lab 07 Other (Specify)
Hospital: 08 O.P. clinic 09 Emergency room 10 Doctor's office 11 Lab 12 Overnight patient (6) 88 Other (Specify)

Ask 3b if under 14.
3a. Did -- actually talk to a medical doctor?
b. Did anyone actually talk to a medical doctor about --?
c. What type of medical person or assistant was talked to?
d. Does the (entry in 3c) work with or for ONE doctor or MORE than one doctor?
e. For this [visit/call] what kind of doctor was the (entry in 3c) working with or for -- a general practitioner or a specialist?
f. Is that doctor a general practitioner or a specialist?
g. What kind of specialist?

3a. and b. 1 Yes (3f) 2 No (3c) 8 DK if M.D. (3c) 9 DK who was seen (3f)
c. _____ Type _____ 99 DK
d. 1 One (3f) 2 More 3 None (4) 9 DK
e. and f. 1 GP (4) 2 Specialist (3g) 9 DK (4)
g. _____ Kind of specialist

Ask 4b if under 14.
4a. For what condition did -- see or talk to the [doctor/(entry in 3c)] on (date in 1)? Mark first appropriate box.
b. For what condition did anyone see or talk to the [doctor/(entry in 3c)] about -- on (date in 1)? Mark first appropriate box.
c. Was a condition found as a result of the [test(s)/examination]?
d. Was this [test/examination] because of a specific condition -- had?
e. During the past 2 weeks was -- sick because of her pregnancy?
f. What was the matter?
g. During this [visit/call] was the [doctor/(entry in 3c)] talked to about any (other) condition?
h. What was the condition?

4a. and b. 1 Condition (Item C2, THEN 4g) 2 Pregnancy (4e) 3 Test(s) or examination (4c) 8 Other (Specify) (4g)
c. Yes (4h) No
d. Yes (4h) No (4g)
e. Yes No (4g)
f. _____ Condition (Item C2, THEN 4g)
g. Yes No (5)
h. Pregnancy (4e) _____ Condition (Item C2, THEN 4g)

Mark box if "Telephone" in 2.
5a. Did -- have any kind of surgery or operation during this visit, including bone settings and stitches?
b. What was the name of the surgery or operation? If name of operation not known, describe what was done.
c. Was there any other surgery or operation during this visit?

5a. 0 Telephone in 2 (Next Dr. visit) 1 Yes 2 No (6)
b. (1) _____
(2) _____
c. Yes (Reask 5b and c) No

Go to next DV if "Home" in 2.
6. In what city (town), county, and State is the (place in 2) located?

6. City/County _____ / _____
State/ZIP Code _____ / _____

G. HEALTH INDICATOR PAGE

1a. During the 2-week period outlined in red on that calendar, has anyone in the family had an injury from an accident or other cause that you have not yet told me about?
 Yes No (2)

b. Who was this? Mark "Injury" box in person's column.

1b. Injury

c. What was -- injury?
Enter injury(ies) in person's column.

c. _____
Injury

d. Did anyone have any other injuries during that period?

Yes (Reask 1b, c, and d) No

Ask for each injury in 1c:

e. As a result of the (injury in 1c) did [---/anyone] see or talk to a medical doctor or assistant (about ---) or did --- cut down on --- usual activities for more than half of a day?

e. Yes (Enter injury in C2, THEN 1e for next injury)
 No (1e for next injury)

2. During the past 12 months, {that is, since (12-month date) a year ago} ABOUT how many days did illness or injury keep --- in bed more than half of the day? (Include days while an overnight patient in a hospital.)

2. 000 None
 _____ No. of days

3a. During the past 12 months, ABOUT how many times did [---/anyone] see or talk to a medical doctor or assistant (about ---)? (Do not count doctors seen while an overnight patient in a hospital.) (Include the (number in 2-WK DV box) visit(s) you already told me about.)

3a. 000 None (3b)
 000 Only when overnight patient in hospital } (NP)
 _____ No. of visits

b. About how long has it been since [---/anyone] last saw or talked to a medical doctor or assistant (about ---)? Include doctors seen while a patient in a hospital.

b. 1 Interview week (Reask 3b)
 2 Less than 1 yr. (Reask 3a)
 3 1 yr., less than 2 yrs.
 4 2 yrs., less than 5 yrs.
 5 5 yrs. or more
 0 Never

4. Would you say --- health in general is excellent, very good, good, fair, or poor?

4. 1 Excellent 4 Fair
 2 Very good 5 Poor
 3 Good

Mark box if under 18.

5a. About how tall is --- without shoes?

5a. Under 18 (NP)
 _____ Feet _____ Inches

b. About how much does --- weigh without shoes?

b. _____ Pounds

FOOTNOTES

H. CONDITION LISTS 1 AND 2

Read to respondent(s) and ask list specified in A2:

Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

| 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|-----------------|------------------------|--------------------|--|---------------------|---|-------------------------------------|------------------------------|---|-------------------------|---------------------------------------|-------------------------------------|---|---|---------------------|---|--|---|--|---|--|---|---|--|--|--|---|--|----------------------------------|----------------------|-----------------------------------|---------------------|---|----------------------------|---|---|-----------------------|---|-------------------------|--------------------------------------|--|-------------------------------------|--|------------------------------------|-------------------------------|---|---|--|--|
| <p>1a. Does anyone in the family {read names} NOW HAVE — If "Yes," ask 1b and c.</p> <p>b. Who is this?</p> <p>c. Does anyone else NOW have — Enter condition and letter in appropriate person's column.</p> <p>A. PERMANENT stiffness or any deformity of the foot, leg, fingers, arm, or back? (Permanent stiffness — joints will not move at all.)</p> <p>-----</p> <p>B. Paralysis of any kind?</p> <p>-----</p> <p>1d. DURING THE PAST 12 MONTHS, did anyone in the family have — If "Yes," ask 1e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. C—L are conditions affecting the bone and muscle. M—W are conditions affecting the skin.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">C. Arthritis of any kind or rheumatism?</td> <td style="width: 50%; padding: 2px;"><i>Reask 1d</i> M. A tumor, cyst, or growth of the skin?</td> </tr> <tr> <td style="padding: 2px;">D. Gout?</td> <td style="padding: 2px;">N. Skin cancer?</td> </tr> <tr> <td style="padding: 2px;">E. Lumbago?</td> <td style="padding: 2px;">O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis)</td> </tr> <tr> <td style="padding: 2px;">F. Sciatica?</td> <td style="padding: 2px;">P. TROUBLE with dry or itching skin?</td> </tr> <tr> <td style="padding: 2px;">G. A bone cyst or bone spur?</td> <td style="padding: 2px;">Q. TROUBLE with acne?</td> </tr> <tr> <td style="padding: 2px;">H. Any other disease of the bone or cartilage?</td> <td style="padding: 2px;">R. A skin ulcer?</td> </tr> <tr> <td style="padding: 2px;">I. A slipped or ruptured disc?</td> <td style="padding: 2px;">S. Any kind of skin allergy?</td> </tr> <tr> <td style="padding: 2px;">J. REPEATED trouble with neck, back, or spine?</td> <td style="padding: 2px;">T. Dermatitis or any other skin trouble?</td> </tr> <tr> <td style="padding: 2px;">K. Bursitis?</td> <td style="padding: 2px;">U. TROUBLE with ingrown toenails or fingernails?</td> </tr> <tr> <td style="padding: 2px;">L. Any disease of the muscles or tendons?</td> <td style="padding: 2px;">V. TROUBLE with bunions, corns, or calluses?</td> </tr> <tr> <td></td> <td style="padding: 2px;">W. Any disease of the hair or scalp?</td> </tr> </table> | C. Arthritis of any kind or rheumatism? | <i>Reask 1d</i> M. A tumor, cyst, or growth of the skin? | D. Gout? | N. Skin cancer? | E. Lumbago? | O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis) | F. Sciatica? | P. TROUBLE with dry or itching skin? | G. A bone cyst or bone spur? | Q. TROUBLE with acne? | H. Any other disease of the bone or cartilage? | R. A skin ulcer? | I. A slipped or ruptured disc? | S. Any kind of skin allergy? | J. REPEATED trouble with neck, back, or spine? | T. Dermatitis or any other skin trouble? | K. Bursitis? | U. TROUBLE with ingrown toenails or fingernails? | L. Any disease of the muscles or tendons? | V. TROUBLE with bunions, corns, or calluses? | | W. Any disease of the hair or scalp? | <p>2a. Does anyone in the family {read names} NOW HAVE — If "Yes," ask 2b and c.</p> <p>b. Who is this?</p> <p>c. Does anyone else NOW have — Enter condition and letter in appropriate person's column. A—L are conditions affecting { Hearing Vision Speech } Conditions M—AA are impairments.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. Deafness in one or both ears?</td> <td style="width: 50%; padding: 2px;"><i>Reask 2a</i> O. A missing joint?</td> </tr> <tr> <td style="padding: 2px;">B. Any other trouble hearing with one or both ears?</td> <td style="padding: 2px;">P. A missing breast, kidney, or lung?</td> </tr> <tr> <td style="padding: 2px;">C. Tinnitus or ringing in the ears?</td> <td style="padding: 2px;">Q. Palsy or cerebral palsy? (ser'a-bral)</td> </tr> <tr> <td style="padding: 2px;">D. Blindness in one or both eyes?</td> <td style="padding: 2px;">R. Paralysis of any kind?</td> </tr> <tr> <td style="padding: 2px;">E. Cataracts?</td> <td style="padding: 2px;">S. Curvature of the spine?</td> </tr> <tr> <td style="padding: 2px;">F. Glaucoma?</td> <td style="padding: 2px;">T. REPEATED trouble with neck, back, or spine?</td> </tr> <tr> <td style="padding: 2px;">G. Color blindness?</td> <td style="padding: 2px;">U. Any TROUBLE with fallen arches or flatfeet?</td> </tr> <tr> <td style="padding: 2px;">H. A detached retina or any other condition of the retina?</td> <td style="padding: 2px;">V. A clubfoot?</td> </tr> <tr> <td style="padding: 2px;">I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?</td> <td style="padding: 2px;">W. A trick knee?</td> </tr> <tr> <td style="padding: 2px;">J. A cleft palate or harelip?</td> <td style="padding: 2px;">X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.)</td> </tr> <tr> <td style="padding: 2px;">K. Stammering or stuttering?</td> <td style="padding: 2px;">Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm?</td> </tr> <tr> <td style="padding: 2px;">L. Any other speech defect?</td> <td style="padding: 2px;">Z. Mental retardation?</td> </tr> <tr> <td style="padding: 2px;">M. Loss of taste or smell which has lasted 3 months or more?</td> <td style="padding: 2px;">AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?</td> </tr> <tr> <td style="padding: 2px;">N. A missing finger, hand, or arm; toe, foot, or leg?</td> <td></td> </tr> </table> | A. Deafness in one or both ears? | <i>Reask 2a</i> O. A missing joint? | B. Any other trouble hearing with one or both ears? | P. A missing breast, kidney, or lung? | C. Tinnitus or ringing in the ears? | Q. Palsy or cerebral palsy? (ser'a-bral) | D. Blindness in one or both eyes? | R. Paralysis of any kind? | E. Cataracts? | S. Curvature of the spine? | F. Glaucoma? | T. REPEATED trouble with neck, back, or spine? | G. Color blindness? | U. Any TROUBLE with fallen arches or flatfeet? | H. A detached retina or any other condition of the retina? | V. A clubfoot? | I. Any other trouble seeing with one or both eyes EVEN when wearing glasses? | W. A trick knee? | J. A cleft palate or harelip? | X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.) | K. Stammering or stuttering? | Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm? | L. Any other speech defect? | Z. Mental retardation? | M. Loss of taste or smell which has lasted 3 months or more? | AA. Any condition caused by an accident or injury which happened more than 3 months ago? 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| C. Arthritis of any kind or rheumatism? | <i>Reask 1d</i> M. A tumor, cyst, or growth of the skin? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Gout? | N. Skin cancer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Lumbago? | O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Sciatica? | P. TROUBLE with dry or itching skin? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. A bone cyst or bone spur? | Q. TROUBLE with acne? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. Any other disease of the bone or cartilage? | R. A skin ulcer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A slipped or ruptured disc? | S. Any kind of skin allergy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. REPEATED trouble with neck, back, or spine? | T. Dermatitis or any other skin trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Bursitis? | U. TROUBLE with ingrown toenails or fingernails? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. Any disease of the muscles or tendons? | V. TROUBLE with bunions, corns, or calluses? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | W. Any disease of the hair or scalp? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. Deafness in one or both ears? | <i>Reask 2a</i> O. A missing joint? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Any other trouble hearing with one or both ears? | P. A missing breast, kidney, or lung? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Tinnitus or ringing in the ears? | Q. Palsy or cerebral palsy? (ser'a-bral) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Blindness in one or both eyes? | R. Paralysis of any kind? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Cataracts? | S. Curvature of the spine? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Glaucoma? | T. REPEATED trouble with neck, back, or spine? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Color blindness? | U. Any TROUBLE with fallen arches or flatfeet? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. A detached retina or any other condition of the retina? | V. A clubfoot? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. Any other trouble seeing with one or both eyes EVEN when wearing glasses? | W. A trick knee? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. A cleft palate or harelip? | X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness — joints will not move at all.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Stammering or stuttering? | Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. Any other speech defect? | Z. Mental retardation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. Loss of taste or smell which has lasted 3 months or more? | AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N. A missing finger, hand, or arm; toe, foot, or leg? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

H. CONDITION LISTS 3 AND 4

Read to respondent(s) and ask list specified in A2:

Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-----------------|-----------------------------------|---------------|----------------------------|--|-----------------|-------------|---------------|---------------------|---------------------|---------------------------|-----------------------------|-----------------------------|--------------|----------------------------------|-------------------------|---|----------------------------------|---|---------------|---|--------------------------|--|-------------------------------|--|--|---------------------------------------|-----------------|--------------|------------------------------|------------------------|---------------------|--------------|---------------------------------------|--|----------------------|------------------------|-------------------|--------------|-----------------------------|------------------------|---------------------------------|---------------------------|---------------------------------|---------------|---|-------------------|---|--------------------------------|--|----------------------|--------------------------------|
| <p align="center" style="font-size: 24pt; font-weight: bold;">3</p> <p>3a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 3b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list. Conditions affecting the digestive system.</p> | <p align="center" style="font-size: 24pt; font-weight: bold;">4</p> <p>4a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 4b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. A—B are conditions affecting the glandular system. C is a blood condition. D—I are conditions affecting the nervous system. J—Y are conditions affecting the genito-urinary system.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. Gallstones?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 3a</i></td> </tr> <tr> <td style="padding: 2px;">B. Any other gallbladder trouble?</td> <td style="padding: 2px;">N. Enteritis?</td> </tr> <tr> <td style="padding: 2px;">C. Cirrhosis of the liver?</td> <td style="padding: 2px;">O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)</td> </tr> <tr> <td style="padding: 2px;">D. Fatty liver?</td> <td style="padding: 2px;">P. Colitis?</td> </tr> <tr> <td style="padding: 2px;">E. Hepatitis?</td> <td style="padding: 2px;">Q. A spastic colon?</td> </tr> <tr> <td style="padding: 2px;">F. Yellow jaundice?</td> <td style="padding: 2px;">R. FREQUENT constipation?</td> </tr> <tr> <td style="padding: 2px;">G. Any other liver trouble?</td> <td style="padding: 2px;">S. Any other bowel trouble?</td> </tr> <tr> <td style="padding: 2px;">H. An ulcer?</td> <td style="padding: 2px;">T. Any other intestinal trouble?</td> </tr> <tr> <td style="padding: 2px;">I. A hernia or rupture?</td> <td style="padding: 2px;">U. Cancer of the stomach, intestines, colon, or rectum?</td> </tr> <tr> <td style="padding: 2px;">J. Any disease of the esophagus?</td> <td style="padding: 2px;">V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system?</td> </tr> <tr> <td style="padding: 2px;">K. Gastritis?</td> <td style="padding: 2px;"><i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i></td> </tr> <tr> <td style="padding: 2px;">L. FREQUENT indigestion?</td> <td></td> </tr> <tr> <td style="padding: 2px;">M. Any other stomach trouble?</td> <td></td> </tr> </table> | A. Gallstones? | <i>Reask 3a</i> | B. Any other gallbladder trouble? | N. Enteritis? | C. Cirrhosis of the liver? | O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis) | D. Fatty liver? | P. Colitis? | E. Hepatitis? | Q. A spastic colon? | F. Yellow jaundice? | R. FREQUENT constipation? | G. Any other liver trouble? | S. Any other bowel trouble? | H. An ulcer? | T. Any other intestinal trouble? | I. A hernia or rupture? | U. Cancer of the stomach, intestines, colon, or rectum? | J. Any disease of the esophagus? | V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system? | K. Gastritis? | <i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i> | L. FREQUENT indigestion? | | M. Any other stomach trouble? | | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. A goiter or other thyroid trouble?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 4a</i></td> </tr> <tr> <td style="padding: 2px;">B. Diabetes?</td> <td style="padding: 2px;">N. Any other kidney trouble?</td> </tr> <tr> <td style="padding: 2px;">C. Anemia of any kind?</td> <td style="padding: 2px;">O. Bladder trouble?</td> </tr> <tr> <td style="padding: 2px;">D. Epilepsy?</td> <td style="padding: 2px;">P. Any disease of the genital organs?</td> </tr> <tr> <td style="padding: 2px;">E. REPEATED seizures, convulsions, or blackouts?</td> <td style="padding: 2px;">Q. A missing breast?</td> </tr> <tr> <td style="padding: 2px;">F. Multiple sclerosis?</td> <td style="padding: 2px;">R. Breast cancer?</td> </tr> <tr> <td style="padding: 2px;">G. Migraine?</td> <td style="padding: 2px;">S. *Cancer of the prostate?</td> </tr> <tr> <td style="padding: 2px;">H. FREQUENT headaches?</td> <td style="padding: 2px;">T. *Any other prostate trouble?</td> </tr> <tr> <td style="padding: 2px;">I. Neuralgia or neuritis?</td> <td style="padding: 2px;">U. **Trouble with menstruation?</td> </tr> <tr> <td style="padding: 2px;">J. Nephritis?</td> <td style="padding: 2px;">V. **A hysterectomy? If "Yes," ask: For what condition did — have a hysterectomy?</td> </tr> <tr> <td style="padding: 2px;">K. Kidney stones?</td> <td style="padding: 2px;">W. **A tumor, cyst, or growth of the uterus or ovaries?</td> </tr> <tr> <td style="padding: 2px;">L. REPEATED kidney infections?</td> <td style="padding: 2px;">X. **Any other disease of the uterus or ovaries?</td> </tr> <tr> <td style="padding: 2px;">M. A missing kidney?</td> <td style="padding: 2px;">Y. **Any other female trouble?</td> </tr> </table> <p style="font-size: 10pt; margin-top: 5px;">*Ask only if males in family. **Ask only if females in family.</p> | A. A goiter or other thyroid trouble? | <i>Reask 4a</i> | B. Diabetes? | N. Any other kidney trouble? | C. Anemia of any kind? | O. Bladder trouble? | D. Epilepsy? | P. Any disease of the genital organs? | E. REPEATED seizures, convulsions, or blackouts? | Q. A missing breast? | F. Multiple sclerosis? | R. Breast cancer? | G. Migraine? | S. *Cancer of the prostate? | H. FREQUENT headaches? | T. *Any other prostate trouble? | I. Neuralgia or neuritis? | U. **Trouble with menstruation? | J. Nephritis? | V. **A hysterectomy? If "Yes," ask: For what condition did — have a hysterectomy? | K. Kidney stones? | W. **A tumor, cyst, or growth of the uterus or ovaries? | L. REPEATED kidney infections? | X. **Any other disease of the uterus or ovaries? | M. A missing kidney? | Y. **Any other female trouble? |
| A. Gallstones? | <i>Reask 3a</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Any other gallbladder trouble? | N. Enteritis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Cirrhosis of the liver? | O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Fatty liver? | P. Colitis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Hepatitis? | Q. A spastic colon? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Yellow jaundice? | R. FREQUENT constipation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Any other liver trouble? | S. Any other bowel trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. An ulcer? | T. Any other intestinal trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A hernia or rupture? | U. Cancer of the stomach, intestines, colon, or rectum? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. Any disease of the esophagus? | V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Gastritis? | <i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. FREQUENT indigestion? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. Any other stomach trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. A goiter or other thyroid trouble? | <i>Reask 4a</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Diabetes? | N. Any other kidney trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Anemia of any kind? | O. Bladder trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Epilepsy? | P. Any disease of the genital organs? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. REPEATED seizures, convulsions, or blackouts? | Q. A missing breast? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Multiple sclerosis? | R. Breast cancer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. Migraine? | S. *Cancer of the prostate? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. FREQUENT headaches? | T. *Any other prostate trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. Neuralgia or neuritis? | U. **Trouble with menstruation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J. Nephritis? | V. **A hysterectomy? If "Yes," ask: For what condition did — have a hysterectomy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. Kidney stones? | W. **A tumor, cyst, or growth of the uterus or ovaries? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. REPEATED kidney infections? | X. **Any other disease of the uterus or ovaries? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. A missing kidney? | Y. **Any other female trouble? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

H. CONDITION LISTS 5 AND 6

Read to respondent(s) and ask list specified in A2.

Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|-----------------------------|-------------------------------|---|----------------------------------|------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------|---------------------|--------------------------------|--------------------|--------------------|--------------------------|-----------------------------|-----------------------------------|-------------------------------|---|---|----------------|---------------------------------|------------|-----------------|---------------|---------------|-------------------|--------------|-------------------|------------------|--|--|--|---|-----------------|--|---|--|---|--|
| <p style="text-align: center; font-size: 24pt; font-weight: bold;">5</p> <p>5a. Has anyone in the family {read names} EVER had — If "Yes," ask 5b and c.</p> <p>b. Who was this?</p> <p>c. Has anyone else EVER had — Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%; padding: 2px;">A. Rheumatic fever?</td> <td style="width: 50%; padding: 2px;">G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar)</td> </tr> <tr> <td style="padding: 2px;">B. Rheumatic heart disease?</td> <td style="padding: 2px;">H. A hemorrhage of the brain?</td> </tr> <tr> <td style="padding: 2px;">C. Hardening of the arteries or arteriosclerosis?</td> <td style="padding: 2px;">I. Angina pectoris? (pek'to-ris)</td> </tr> <tr> <td style="padding: 2px;">D. Congenital heart disease?</td> <td style="padding: 2px;">J. A myocardial infarction?</td> </tr> <tr> <td style="padding: 2px;">E. Coronary heart disease?</td> <td style="padding: 2px;">K. Any other heart attack?</td> </tr> </table> <p>5d. DURING THE PAST 12 MONTHS, did anyone in the family have — If "Yes," ask 5e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%; padding: 2px;">L. Damaged heart valves?</td> <td style="width: 50%; padding: 2px;">Q. Any blood clots?</td> </tr> <tr> <td style="padding: 2px;">M. Tachycardia or rapid heart?</td> <td style="padding: 2px;">R. Varicose veins?</td> </tr> <tr> <td style="padding: 2px;">N. A heart murmur?</td> <td style="padding: 2px;">S. Hemorrhoids or piles?</td> </tr> <tr> <td style="padding: 2px;">O. Any other heart trouble?</td> <td style="padding: 2px;">T. Phlebitis or thrombophlebitis?</td> </tr> <tr> <td style="padding: 2px;">P. An aneurysm? (an yoo-rizm)</td> <td style="padding: 2px;">U. Any other condition affecting blood circulation?</td> </tr> </table> | A. Rheumatic fever? | G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar) | B. Rheumatic heart disease? | H. A hemorrhage of the brain? | C. Hardening of the arteries or arteriosclerosis? | I. Angina pectoris? (pek'to-ris) | D. Congenital heart disease? | J. A myocardial infarction? | E. Coronary heart disease? | K. Any other heart attack? | L. Damaged heart valves? | Q. Any blood clots? | M. Tachycardia or rapid heart? | R. Varicose veins? | N. A heart murmur? | S. Hemorrhoids or piles? | O. Any other heart trouble? | T. Phlebitis or thrombophlebitis? | P. An aneurysm? (an yoo-rizm) | U. Any other condition affecting blood circulation? | <p style="text-align: center; font-size: 24pt; font-weight: bold;">6</p> <p>6a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 6b and c.</p> <p>b. Who was this?</p> <p>c. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column. Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list. Conditions affecting the respiratory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 50%; padding: 2px;">A. Bronchitis?</td> <td style="width: 50%; padding: 2px;">Reask 6a. K. A missing lung?</td> </tr> <tr> <td style="padding: 2px;">B. Asthma?</td> <td style="padding: 2px;">L. Lung cancer?</td> </tr> <tr> <td style="padding: 2px;">C. Hay fever?</td> <td style="padding: 2px;">M. Emphysema?</td> </tr> <tr> <td style="padding: 2px;">D. Sinus trouble?</td> <td style="padding: 2px;">N. Pleurisy?</td> </tr> <tr> <td style="padding: 2px;">E. A nasal polyp?</td> <td style="padding: 2px;">O. Tuberculosis?</td> </tr> <tr> <td style="padding: 2px;">F. A deflected or deviated nasal septum?</td> <td style="padding: 2px;">P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis?</td> </tr> <tr> <td style="padding: 2px;">G. *Tonsillitis or enlargement of the tonsils or adenoids?</td> <td style="padding: 2px;">Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q.</td> </tr> <tr> <td style="padding: 2px;">H. *Laryngitis?</td> <td></td> </tr> <tr> <td style="padding: 2px;">I. A tumor or growth of the throat, larynx, or trachea?</td> <td></td> </tr> <tr> <td style="padding: 2px;">J. A tumor or growth of the bronchial tube or lung?</td> <td></td> </tr> </table> <p style="margin-top: 10px;">*If reported in this list only, ask:</p> <p>1. How many times did — have (condition) in the past 12 months? If 2 or more times, enter condition in item C2. If only 1 time, ask:</p> <p>2. How long did it last? If 1 month or longer, enter in item C2. If less than 1 month, do not record. If tonsils or adenoids were removed during past 12 months, enter the condition causing removal in item C2.</p> | A. Bronchitis? | Reask 6a. K. A missing lung? | B. Asthma? | L. Lung cancer? | C. Hay fever? | M. Emphysema? | D. Sinus trouble? | N. Pleurisy? | E. A nasal polyp? | O. Tuberculosis? | F. A deflected or deviated nasal septum? | P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis? | G. *Tonsillitis or enlargement of the tonsils or adenoids? | Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q. | H. *Laryngitis? | | I. A tumor or growth of the throat, larynx, or trachea? | | J. A tumor or growth of the bronchial tube or lung? | |
| A. Rheumatic fever? | G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Rheumatic heart disease? | H. A hemorrhage of the brain? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Hardening of the arteries or arteriosclerosis? | I. Angina pectoris? (pek'to-ris) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Congenital heart disease? | J. A myocardial infarction? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. Coronary heart disease? | K. Any other heart attack? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. Damaged heart valves? | Q. Any blood clots? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. Tachycardia or rapid heart? | R. Varicose veins? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N. A heart murmur? | S. Hemorrhoids or piles? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| O. Any other heart trouble? | T. Phlebitis or thrombophlebitis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| P. An aneurysm? (an yoo-rizm) | U. Any other condition affecting blood circulation? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A. Bronchitis? | Reask 6a. K. A missing lung? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B. Asthma? | L. Lung cancer? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Hay fever? | M. Emphysema? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| D. Sinus trouble? | N. Pleurisy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. A nasal polyp? | O. Tuberculosis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. A deflected or deviated nasal septum? | P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. *Tonsillitis or enlargement of the tonsils or adenoids? | Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| H. *Laryngitis? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A tumor or growth of the throat, larynx, or trachea? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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J. HOSPITAL PAGE

HOSPITAL STAY 1

| | | | | | | | | | |
|---|--|--|------|-------------------|--|---|------------------------------------|--|---|
| <p>1. Refer to C1, "HOSP." box.</p> | <p>1. PERSON NUMBER _____</p> | | | | | | | | |
| <p>2. You said earlier that — was a patient in the hospital since (13-month hospital date) a year ago. On what date did — enter the hospital ([the last time/the time before that])? <i>Record each entry date in a separate Hospital Stay column.</i></p> | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Month</td> <td style="width:25%;">Date</td> <td style="width:50%;">Year</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">19 ____</td> </tr> </table> | Month | Date | Year | | | 19 ____ | | |
| Month | Date | Year | | | | | | | |
| | | 19 ____ | | | | | | | |
| <p>3. How many nights was — in the hospital?</p> | <p>3. 0000 <input type="checkbox"/> None (Next HS)</p> <p style="text-align: center;">_____ Nights</p> | | | | | | | | |
| <p>4. For what condition did — enter the hospital?</p> <ul style="list-style-type: none"> • For delivery ask: Was this a normal delivery? If "No," ask: What was the matter? • For newborn ask: Was the baby normal at birth? If "No," ask: What was the matter? • For initial "No condition" ask: Why did — enter the hospital? For tests, ask: What were the results of the tests? If no results, ask: Why were the tests performed? | <p>4.</p> <table style="width:100%;"> <tr> <td style="width:15%;">1 <input type="checkbox"/> Normal delivery</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(5)</td> </tr> <tr> <td>2 <input type="checkbox"/> Normal at birth</td> </tr> <tr> <td>3 <input type="checkbox"/> No condition</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Condition</td> <td style="text-align: right;">✓</td> </tr> </table> <p>_____</p> | 1 <input type="checkbox"/> Normal delivery | } | (5) | 2 <input type="checkbox"/> Normal at birth | 3 <input type="checkbox"/> No condition | <input type="checkbox"/> Condition | | ✓ |
| 1 <input type="checkbox"/> Normal delivery | } | (5) | | | | | | | |
| 2 <input type="checkbox"/> Normal at birth | | | | | | | | | |
| 3 <input type="checkbox"/> No condition | | | | | | | | | |
| <input type="checkbox"/> Condition | | ✓ | | | | | | | |
| <p>J1 Refer to questions 2, 3, and 2-week reference period.</p> | <p>J1</p> <p><input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2, THEN 5)</p> <p><input type="checkbox"/> No nights in 2-week reference period (5)</p> | | | | | | | | |
| <p>5a. Did — have any kind of surgery or operation during this stay in the hospital, including bone settings and stitches?</p> <hr style="border-top: 1px dashed black;"/> <p>b. What was the name of the surgery or operation? <i>If name of operation not known, describe what was done.</i></p> <hr style="border-top: 1px dashed black;"/> <p>c. Was there any other surgery or operation during this stay?</p> | <p>5a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)</p> <hr style="border-top: 1px dashed black;"/> <p>b.</p> <p>(1) _____</p> <p>(2) _____</p> <p>(3) _____</p> <hr style="border-top: 1px dashed black;"/> <p>c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No</p> | | | | | | | | |
| <p>6. What is the name and address of this hospital?</p> | <p>6.</p> <table style="width:100%;"> <tr> <td colspan="2">Name</td> </tr> <tr> <td colspan="2">Number and street</td> </tr> <tr> <td>City or County</td> <td style="text-align: right;">State</td> </tr> </table> | Name | | Number and street | | City or County | State | | |
| Name | | | | | | | | | |
| Number and street | | | | | | | | | |
| City or County | State | | | | | | | | |

FOOTNOTES

CONDITION 1

PERSON NO. _____

1. Name of condition

Mark "2-wk. ref. pd." box without asking if "DV" or "HS" in C2 as source.

2. When did [---/anyone] last see or talk to a doctor or assistant about --- (condition)?

- | | |
|---|---|
| <input type="checkbox"/> Interview week (Reask 2) | <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| <input type="checkbox"/> 2-wk. ref. pd. | <input type="checkbox"/> 5 yrs. or more |
| <input type="checkbox"/> Over 2 weeks, less than 6 mos. | <input type="checkbox"/> Dr. seen, DK when |
| <input type="checkbox"/> 6 mos., less than 1 yr. | <input type="checkbox"/> DK if Dr. seen } (3b) |
| <input type="checkbox"/> 1 yr., less than 2 yrs. | <input type="checkbox"/> Dr. never seen } |

3a. (Earlier you told me about --- (condition)) Did the doctor or assistant call the (condition) by a more technical or specific name?

- Yes No DK

Ask 3b if "Yes" in 3a, otherwise transcribe condition name from item 1 without asking:

b. What did he or she call it? _____ (Specify)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Color Blindness (NC) | <input type="checkbox"/> Cancer (3e) |
| <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy } (5) | <input type="checkbox"/> Old age (NC) |
| | <input type="checkbox"/> Other (3c) |

c. What was the cause of --- (condition in 3b)? (Specify) ▾

Mark box if accident or injury. Accident/injury (Probe, then 5)

d. Did the (condition in 3b) result from an accident or injury?

- Yes (Probe, then 5) Ask probes as necessary. Record responses in 3c:
 No (How did the accident happen?)
 (What was --- doing at the time of the injury?)

Ask 3e if the condition name in 3b includes any of the following words:

| | | | |
|---------|-----------|----------|---------|
| Allment | Cancer | Disease | Problem |
| Anemia | Condition | Disorder | Rupture |
| Asthma | Cyst | Growth | Trouble |
| Attack | Defect | Measles | Tumor |
| Bad | | | Ulcer |

e. What kind of (condition in 3b) is it? _____ (Specify)

Ask 3f only if allergy or stroke in 3b—e:

f. How does the [allergy/stroke] NOW affect ---? (Specify) ▾

For Stroke, fill remainder of this condition page for the first present effect. Enter in item C2 and complete a separate condition page for each additional present effect.

Ask 3g if there is an impairment (refer to Card CP2) or any of the following entries in 3b—f:

| | | |
|-----------------------------|--------------|----------------|
| Abcess | Damage | Palsy |
| Ache (except head or ear) | Growth | Paralysis |
| Bleeding (except menstrual) | Hemorrhage | Rupture |
| Blood clot | Infection | Sore(ness) |
| Boll | Inflammation | Stiff(ness) |
| Cancer | Neuralgia | Tumor |
| Cramps (except menstrual) | Neuritis | Ulcer |
| Cyst | Pain | Varicose veins |
| | | Weak(ness) |

g. What part of the body is affected? _____ (Specify)

Show the following detail:

- Head..... skull, scalp, face
 Back/spine/vertebrae..... upper, middle, lower
 Side..... left or right
 Ear..... inner or outer; left, right, or both
 Eye..... left, right, or both
 Arm..... shoulder, upper, elbow, lower or wrist; left, right, or both
 Hand..... entire hand or fingers only; left, right, or both
 Leg..... hip, upper, knee, lower, or ankle; left, right, or both
 Foot..... entire foot, arch, or toes only; left, right, or both

Except for eyes, ears, or internal organs, ask 3h if there are any of the following entries in 3b—f:

- Infection Sore Soreness

h. What part of the (part of body in 3b—g) is affected by the [infection/sore/soreness] — the skin, muscle, bone, or some other part?

(Specify) _____

Ask if there are any of the following entries in 3b—f:

- Tumor Cyst Growth

4. Is this [tumor/cyst/growth] malignant or benign?

- Malignant Benign DK

- 5** **a. When was --- (condition in 3b/3f) first noticed?** 2-wk. ref. pd.
 Over 2 weeks to 3 months
 Over 3 months to 1 year
b. When did --- (name of injury in 3b)? Over 1 year to 5 years
 Over 5 years

Ask probes as necessary:

(Was it on or since (first date of 2-week ref. period) or was it before that date?)

(Was it less than 3 months or more than 3 months ago?)

(Was it less than 1 year or more than 1 year ago?)

(Was it less than 5 years or more than 5 years ago?)

K1 Refer to RD and C2.
 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?
 Yes No (K2)

b. During that period, how many days did -- cut down for more than half of the day?
 00 None (K2) _____ Days

7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?
 00 None _____ Days

8. Ask if "Wa/Wb" box marked in C1: During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?
 00 None _____ Days

9. Ask if age 5-17: During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?
 00 None _____ Days

K2 Condition has "CL LTR" in C2 as source (10)
 Condition does not have "CL LTR" in C2 as source (K4)

10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)
 000 None _____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?
 1 Yes 2 No

K3 Missing extremity or organ (K4)
 Other (12)

12a. Does -- still have this condition?
 1 Yes (K4) No

b. Is this condition completely cured or is it under control?
 2 Cured 8 Other (Specify) _____
 3 Under control (K4) _____ (K4)

c. About how long did -- have this condition before it was cured?
 000 Less than 1 month OR Number { 1 Months
 2 Years

d. Was this condition present at any time during the past 12 months?
 1 Yes 2 No

K4 0 Not an accident/injury (NC)
 1 First accident/injury for this person (14)
 8 Other (13)

13. Is this (condition in 3b) the result of the same accident you already told me about?
 Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No.
 No

14. Where did the accident happen?
 1 At home (inside house)
 2 At home (adjacent premises)
 3 Street and highway (includes roadway and public sidewalk)
 4 Farm
 5 Industrial place (includes premises) (Specify) _____
 6 School (includes premises)
 7 Place of recreation and sports, except at school
 8 Other (Specify) _____

Mark box if under 18. Under 18 (16)

15a. Was -- under 18 when the accident happened?
 1 Yes (16) No

b. Was -- in the Armed Forces when the accident happened?
 2 Yes (16) No

c. Was -- at work at -- job or business when the accident happened?
 3 Yes 4 No

16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?
 1 Yes 2 No (17)

b. Was more than one vehicle involved?
 1 Yes 2 No

c. Was [it/either one] moving at the time?
 1 Yes 2 No

17a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else?

| Part(s) of body * | Kind of injury |
|-------------------|----------------|
| | |
| | |
| | |

Ask if box 3, 4, or 5 marked in Q. 5:

b. What part of the body is affected now? How is -- (part of body) affected? Is -- affected in any other way?

| Part(s) of body * | Present effects ** |
|-------------------|--------------------|
| | |
| | |
| | |

* Enter part of body in same detail as for 3g.
 ** If multiple present effects, enter in C2 each one that is not the same as 3b or C2 and complete a separate condition page for it.

L. DEMOGRAPHIC BACKGROUND PAGE

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--------------------------------|--|---|-------------------------------|--------------------------------|-------------------------------|-------------------------------|---------------------------------|-------------------------------|--|--------------------------|-----------------------|--|--------------|-------------------|---------------------------|--|--|------------|-------------|--|---|--|
| <p>L1</p> | <p>Refer to age.</p> | <p>L1</p> | <p><input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)</p> | | | | | | | | | | | | | | | | | | | | |
| <p>1 a. Did --- EVER serve on active duty in the Armed Forces of the United States?</p> <p>b. When did --- serve?</p> <p>Mark box in descending order of priority. Thus, if person served in Vietnam and in Korea mark VN.</p> <p>c. Was --- EVER an active member of a National Guard or military reserve unit?</p> <p>d. Was ALL of --- active duty service related to National Guard or military reserve training?</p> | | <p>1 a.</p> <p>1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (2)</p> <p>b.</p> <table border="0"> <tr> <td>1 <input type="checkbox"/> VN</td> <td>5 <input type="checkbox"/> PVN</td> </tr> <tr> <td>2 <input type="checkbox"/> KW</td> <td>8 <input type="checkbox"/> OS</td> </tr> <tr> <td>3 <input type="checkbox"/> WWII</td> <td>9 <input type="checkbox"/> DK</td> </tr> <tr> <td>4 <input type="checkbox"/> WWI</td> <td></td> </tr> </table> <p>c.</p> <p><input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)</p> <p>d.</p> <p>1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> | | 1 <input type="checkbox"/> VN | 5 <input type="checkbox"/> PVN | 2 <input type="checkbox"/> KW | 8 <input type="checkbox"/> OS | 3 <input type="checkbox"/> WWII | 9 <input type="checkbox"/> DK | 4 <input type="checkbox"/> WWI | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> VN | 5 <input type="checkbox"/> PVN | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> KW | 8 <input type="checkbox"/> OS | | | | | | | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> WWII | 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> WWI | | | | | | | | | | | | | | | | | | | | | | | |
| <p>2a. What is the highest grade or year of regular school --- has ever attended?</p> <p>b. Did --- finish the (number in 2a) [grade/year]?</p> | | <p>2a.</p> <p>00 <input type="checkbox"/> Never attended or kindergarten (NP)</p> <p>Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6 +</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> | | | | | | | | | | | | | | | | | | | | | |
| <p>Hand Card O.</p> <p>3a. Are any of those groups --- National origin or ancestry? (Where did --- ancestors come from?)</p> <p>b. Please give me the number of the group. Circle all that apply.</p> <table border="0"> <tr> <td>1 - Puerto Rican</td> <td>3 - Mexican/Mexicano</td> <td>5 - Chicano</td> <td>7 - Other Spanish</td> </tr> <tr> <td>2 - Cuban</td> <td>4 - Mexican American</td> <td>6 - Other Latin American</td> <td></td> </tr> </table> | | 1 - Puerto Rican | 3 - Mexican/Mexicano | 5 - Chicano | 7 - Other Spanish | 2 - Cuban | 4 - Mexican American | 6 - Other Latin American | | <p>3a.</p> <p>1 <input type="checkbox"/> Yes (3b) 2 <input type="checkbox"/> No (NP)</p> <p>b.</p> <p>1 2 3 4 5 6 7</p> | | | | | | | | | | | | | |
| 1 - Puerto Rican | 3 - Mexican/Mexicano | 5 - Chicano | 7 - Other Spanish | | | | | | | | | | | | | | | | | | | | |
| 2 - Cuban | 4 - Mexican American | 6 - Other Latin American | | | | | | | | | | | | | | | | | | | | | |
| <p>Hand Card R. Ask first alternative for first person; ask second alternative for other persons.</p> <p>4a. [What is the number of the group or groups which represents --- race?] [What is --- race?]</p> <p>Circle all that apply</p> <table border="0"> <tr> <td>1 - White</td> <td>4 - Eskimo</td> <td>6 - Chinese</td> <td>10 - Vietnamese</td> <td>14 - Guamanian</td> </tr> <tr> <td>2 - Black</td> <td>5 - Aleut</td> <td>7 - Filipino</td> <td>11 - Japanese</td> <td>15 - Other API - Specify</td> </tr> <tr> <td>3 - Indian (American)</td> <td></td> <td>8 - Hawaiian</td> <td>12 - Asian Indian</td> <td>16 - Other race - Specify</td> </tr> <tr> <td></td> <td></td> <td>9 - Korean</td> <td>13 - Samoan</td> <td></td> </tr> </table> <p>Ask if multiple entries:</p> <p>b. Which of those groups; that is, (entries in 4a) would you say BEST represents --- race?</p> <p>c. Mark observed race of respondent(s) only.</p> | | 1 - White | 4 - Eskimo | 6 - Chinese | 10 - Vietnamese | 14 - Guamanian | 2 - Black | 5 - Aleut | 7 - Filipino | 11 - Japanese | 15 - Other API - Specify | 3 - Indian (American) | | 8 - Hawaiian | 12 - Asian Indian | 16 - Other race - Specify | | | 9 - Korean | 13 - Samoan | | <p>4a.</p> <p>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 ▾ 16 ▾</p> <p>(Specify)</p> <p>b.</p> <p>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 ▾ 16 ▾</p> <p>(Specify)</p> <p>c.</p> <p>1 <input type="checkbox"/> W 2 <input type="checkbox"/> B 3 <input type="checkbox"/> O</p> | |
| 1 - White | 4 - Eskimo | 6 - Chinese | 10 - Vietnamese | 14 - Guamanian | | | | | | | | | | | | | | | | | | | |
| 2 - Black | 5 - Aleut | 7 - Filipino | 11 - Japanese | 15 - Other API - Specify | | | | | | | | | | | | | | | | | | | |
| 3 - Indian (American) | | 8 - Hawaiian | 12 - Asian Indian | 16 - Other race - Specify | | | | | | | | | | | | | | | | | | | |
| | | 9 - Korean | 13 - Samoan | | | | | | | | | | | | | | | | | | | | |

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

| | | | |
|---|--|--|---|
| <p>L2</p> | <p>Refer to "Age" and "Wa/Wb" boxes in C1.</p> | <p>L2</p> | <p>0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)</p> |
| <p>5a. Earlier you said that — has a job or business but did not work last week or the week before. Was — looking for work or on layoff from a job during those 2 weeks?</p> | | <p>5a. 1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)</p> | |
| <p>b. Earlier you said that — didn't have a job or business last week or the week before. Was — looking for work or on layoff from a job during those 2 weeks?</p> | | <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> | |
| <p>c. Which, looking for work or on layoff from a job?</p> | | <p>c. 1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)</p> | |
| <p>6a. Earlier you said that — worked last week or the week before. Ask 6b.</p> | | | |
| <p>b. For whom did — work? Enter name of company, business, organization, or other employer.</p> | | <p>6b. and c. Employer <input type="checkbox"/> NEV (6g) <input type="checkbox"/> AF (6e)</p> | |
| <p>c. For whom did — work at — last full-time job or business lasting 2 consecutive weeks or more? Enter name of company, business, organization, or other employer, or mark "NEV" or "AF" box in person's column.</p> | | | |
| <p>d. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.</p> | | <p>d. Industry</p> | |
| <p><i>If "AF" in 6b/c, mark "AF" box in person's column without asking.</i></p> | | | |
| <p>e. What kind of work was — doing? For example, electrical engineer, stock clerk, typist, farmer.</p> | | <p>e. Occupation <input type="checkbox"/> AF (NP)</p> | |
| <p>f. What were — most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.</p> | | <p>f. Duties</p> | |
| <p><i>Complete from entries in 6b–f. If not clear, ask:</i></p> | | | |
| <p>g. Was — An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A FEDERAL government employee? F A STATE government employee? S A LOCAL government employee? L</p> <p>Self-employed in OWN business, professional practice, or farm? Ask: Is the business incorporated? Yes I No SE</p> <p>Working WITHOUT PAY in family business or farm? WP — NEVER WORKED or never worked at a full-time job lasting 2 weeks or more NEV</p> | | <p>g. Class of worker</p> <p>1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV</p> | |
| <p>FOOTNOTES</p> | | | |

L.DEMOGRAPHIC BACKGROUND PAGE, Continued

| | |
|--|--|
| <p>Mark box if under 14. If "Married" refer to household composition and mark accordingly.</p> <p>7. Is -- now married, widowed, divorced, separated, or has -- never been married?</p> | <p>7.</p> <p>0 <input type="checkbox"/> Under 14 1 <input type="checkbox"/> Married -- spouse in HH 2 <input type="checkbox"/> Married -- spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married</p> |
|--|--|

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------|-------------------------------|-------------------------------|--|-------------------------------|-------------------------------|--|-------------------------------|-------------------------------|--|
| <p>8a. Was the total combined FAMILY income during the past 12 months -- that is, yours, (read names, including Armed Forces members living at home) more or less than \$20,000? Include money from jobs, social security, retirement income, unemployment payments, public assistance, and so forth. Also include income from interest, dividends, net income from business, farm, or rent, and any other money income received.</p> <p><i>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</i></p> <p><i>Read parenthetical phrase if Armed Forces member living at home or if necessary.</i></p> <p>b. Of those income groups, which letter best represents the total combined FAMILY income during the past 12 months (that is, yours, (read names, including Armed Forces members living at home))? Include wages, salaries, and other items we just talked about.</p> <p><i>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</i></p> | <p>8a.</p> <p>1 <input type="checkbox"/> \$20,000 or more (Hand Card I) 2 <input type="checkbox"/> Less than \$20,000 (Hand Card J)</p> <p>b.</p> <table border="0"> <tr> <td>00 <input type="checkbox"/> A</td> <td>10 <input type="checkbox"/> K</td> <td>20 <input type="checkbox"/> U</td> </tr> <tr> <td>01 <input type="checkbox"/> B</td> <td>11 <input type="checkbox"/> L</td> <td>21 <input type="checkbox"/> V</td> </tr> <tr> <td>02 <input type="checkbox"/> C</td> <td>12 <input type="checkbox"/> M</td> <td>22 <input type="checkbox"/> W</td> </tr> <tr> <td>03 <input type="checkbox"/> D</td> <td>13 <input type="checkbox"/> N</td> <td>23 <input type="checkbox"/> X</td> </tr> <tr> <td>04 <input type="checkbox"/> E</td> <td>14 <input type="checkbox"/> O</td> <td>24 <input type="checkbox"/> Y</td> </tr> <tr> <td>05 <input type="checkbox"/> F</td> <td>15 <input type="checkbox"/> P</td> <td>25 <input type="checkbox"/> Z</td> </tr> <tr> <td>06 <input type="checkbox"/> G</td> <td>16 <input type="checkbox"/> Q</td> <td>26 <input type="checkbox"/> ZZ</td> </tr> <tr> <td>07 <input type="checkbox"/> H</td> <td>17 <input type="checkbox"/> R</td> <td></td> </tr> <tr> <td>08 <input type="checkbox"/> I</td> <td>18 <input type="checkbox"/> S</td> <td></td> </tr> <tr> <td>09 <input type="checkbox"/> J</td> <td>19 <input type="checkbox"/> T</td> <td></td> </tr> </table> | 00 <input type="checkbox"/> A | 10 <input type="checkbox"/> K | 20 <input type="checkbox"/> U | 01 <input type="checkbox"/> B | 11 <input type="checkbox"/> L | 21 <input type="checkbox"/> V | 02 <input type="checkbox"/> C | 12 <input type="checkbox"/> M | 22 <input type="checkbox"/> W | 03 <input type="checkbox"/> D | 13 <input type="checkbox"/> N | 23 <input type="checkbox"/> X | 04 <input type="checkbox"/> E | 14 <input type="checkbox"/> O | 24 <input type="checkbox"/> Y | 05 <input type="checkbox"/> F | 15 <input type="checkbox"/> P | 25 <input type="checkbox"/> Z | 06 <input type="checkbox"/> G | 16 <input type="checkbox"/> Q | 26 <input type="checkbox"/> ZZ | 07 <input type="checkbox"/> H | 17 <input type="checkbox"/> R | | 08 <input type="checkbox"/> I | 18 <input type="checkbox"/> S | | 09 <input type="checkbox"/> J | 19 <input type="checkbox"/> T | |
| 00 <input type="checkbox"/> A | 10 <input type="checkbox"/> K | 20 <input type="checkbox"/> U | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 01 <input type="checkbox"/> B | 11 <input type="checkbox"/> L | 21 <input type="checkbox"/> V | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02 <input type="checkbox"/> C | 12 <input type="checkbox"/> M | 22 <input type="checkbox"/> W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 03 <input type="checkbox"/> D | 13 <input type="checkbox"/> N | 23 <input type="checkbox"/> X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 04 <input type="checkbox"/> E | 14 <input type="checkbox"/> O | 24 <input type="checkbox"/> Y | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 05 <input type="checkbox"/> F | 15 <input type="checkbox"/> P | 25 <input type="checkbox"/> Z | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 06 <input type="checkbox"/> G | 16 <input type="checkbox"/> Q | 26 <input type="checkbox"/> ZZ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 07 <input type="checkbox"/> H | 17 <input type="checkbox"/> R | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 08 <input type="checkbox"/> I | 18 <input type="checkbox"/> S | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 09 <input type="checkbox"/> J | 19 <input type="checkbox"/> T | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | |
|--|--|
| <p>R</p> <p>a. Mark first appropriate box.</p> <p>b. Enter person number of respondent.</p> | <p>Ra.</p> <p>1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present</p> <p>b.</p> <p>Person number(s) of respondent(s)</p> |
|--|--|

| | |
|---|--|
| <p>L3</p> <p>Enter person number of first parent listed or mark box.</p> | <p>L3</p> <p>Person number of parent</p> <p>00 <input type="checkbox"/> None in household</p> |
|---|--|

| | |
|--|--|
| <p>L4</p> <p>Enter person number of spouse or mark box.</p> | <p>L4</p> <p>Person number of spouse</p> <p>00 <input type="checkbox"/> None in household</p> |
|--|--|

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

| | | | |
|---|--|-------------|---|
| | | RT61 | |
| L5 | <i>Read to respondent(s):</i> In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics. | 3-4 | |
| L6 | <i>Enter date of birth from question 3 on Household Composition page.</i> | L6 | Date of birth 5-11 Month Date Year |
| 9a. In what State or country was -- born? <i>Print the full name of the State or mark the appropriate box if the person was not born in the United States.</i> ----- <i>If born in U.S., ask 9b only; if born in foreign country, ask 9c only.</i> b. Altogether, how many years has -- lived in (State of present residence)? ----- c. Altogether, how many years has -- lived in the United States? | | 9a. | 99 <input type="checkbox"/> DK (L7) 12-13 _____ State 01 <input type="checkbox"/> Puerto Rico 05 <input type="checkbox"/> Cuba 02 <input type="checkbox"/> Virgin Islands 06 <input type="checkbox"/> Mexico 03 <input type="checkbox"/> Guam 98 <input type="checkbox"/> All other countries 04 <input type="checkbox"/> Canada b. 1 <input type="checkbox"/> Less than 1 yr. 14 2 <input type="checkbox"/> 1 yr., less than 5 3 <input type="checkbox"/> 5 yrs., less than 10 4 <input type="checkbox"/> 10 yrs., less than 15 5 <input type="checkbox"/> 15 yrs. or more 9 <input type="checkbox"/> DK |
| | | c. | 1 <input type="checkbox"/> Less than 1 yr. 15 2 <input type="checkbox"/> 1 yr., less than 5 3 <input type="checkbox"/> 5 yrs., less than 10 4 <input type="checkbox"/> 10 yrs., less than 15 5 <input type="checkbox"/> 15 yrs. or more 9 <input type="checkbox"/> DK |
| L7 | <i>Print full name, including middle initial, from question 1 on Household Composition page.</i> | L7 | Last 16-35 First 36-50 Middle initial 51 |
| <i>Verify for males; ask for females.</i> 10. What is -- father's LAST name? Verify spelling. DO NOT write "Same." | | 10. | Father's LAST name 52-71 |
| <i>Read to respondent(s):</i> We also need -- Social Security Number to link with vital statistics and other records of the Department of Health and Human Services to perform health-related research. Providing this information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on -- benefits if you do provide it and this number will not be given to any other government or nongovernment agency. <i>Read if necessary:</i> The Public Health Service Act is title 42, United States Code, section 242k. 11. What is -- Social Security Number? | | 11. | 99999999 <input type="checkbox"/> DK 72-80 [] - [] - [] Social Security Number Mark if number obtained from 81 0 <input type="checkbox"/> Does not have SSN 2 <input type="checkbox"/> Records 1 <input type="checkbox"/> Memory 7 <input type="checkbox"/> Refused |
| L8 | <i>Mark box to indicate how Social Security number was or was not obtained.</i> | L8 | 1 <input type="checkbox"/> Self-personal 82 2 <input type="checkbox"/> Self-telephone 3 <input type="checkbox"/> Proxy-personal 4 <input type="checkbox"/> Proxy-telephone |

| E | If this questionnaire is for an EXTRA unit, enter Control Number of original sample unit → _____ | If in AREA OR BLOCK SEGMENT, also enter for FIRST unit listed on property → _____ | LISTING SHEET | | | |
|--|--|---|--|---|---|---|
| | | | Sheet number | Line number | | |
| TABLE X – LIVING QUARTERS DETERMINATIONS AT LISTED ADDRESS | | | | | | |
| ADDRESS OF ADDITIONAL LIVING QUARTERS | LOCATION OF UNIT | SEPARATENESS AND FACILITIES | | CLASSIFICATION | AREA AND BLOCK SEGMENTS | PERMIT SEGMENTS |
| If already listed, fill sheet and line number below and stop Table X. Otherwise, enter basic address and unit address, if any, OR description of location. | Is this a unit in a special place? | Do the occupants (or intended occupants) of (address in column (1)) live and eat separately from all other persons on the property? | Does (address in col. (1)) have direct access from the outside or through a common hall? | N – Not a separate unit – Include on this questionnaire. HU OT Separate unit – Do not include on this questionnaire. Complete the appropriate segment type column for interviewing instructions. | Is this unit within the segment boundaries? | Is this unit within the same structure as the original sample unit? |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Sheet _____ Line _____ | <input type="checkbox"/> Yes – Skip to column (5) and mark according to Table A in Part C of manual <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No – Skip to column (5) and mark N | <input type="checkbox"/> Yes – Mark HU in column (5) <input type="checkbox"/> No – Mark N in column (5) | <input type="checkbox"/> N – Stop Table X for this line <input type="checkbox"/> HU – Fill column (6) or (7), as appropriate <input type="checkbox"/> OT – Fill column (6) or (7), as appropriate | <input type="checkbox"/> Yes – Interview as an EXTRA unit <input type="checkbox"/> No – Do not interview | <input type="checkbox"/> Yes – List on first available line of listing sheet. Interview if in sample. <input type="checkbox"/> No – Do not interview |
| Sheet _____ Line _____ | <input type="checkbox"/> Yes – Skip to column (5) and mark according to Table A in Part C of manual <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No – Skip to column (5) and mark N | <input type="checkbox"/> Yes – Mark HU in column (5) <input type="checkbox"/> No – Mark N in column (5) | <input type="checkbox"/> N – Stop Table X for this line <input type="checkbox"/> HU – Fill column (6) or (7), as appropriate <input type="checkbox"/> OT – Fill column (6) or (7), as appropriate | <input type="checkbox"/> Yes – Interview as an EXTRA unit <input type="checkbox"/> No – Do not interview | <input type="checkbox"/> Yes – List on first available line of listing sheet. Interview if in sample. <input type="checkbox"/> No – Do not interview |
| Sheet _____ Line _____ | <input type="checkbox"/> Yes – Skip to column (5) and mark according to Table A in Part C of manual <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No – Skip to column (5) and mark N | <input type="checkbox"/> Yes – Mark HU in column (5) <input type="checkbox"/> No – Mark N in column (5) | <input type="checkbox"/> N – Stop Table X for this line <input type="checkbox"/> HU – Fill column (6) or (7), as appropriate <input type="checkbox"/> OT – Fill column (6) or (7), as appropriate | <input type="checkbox"/> Yes – Interview as an EXTRA unit <input type="checkbox"/> No – Do not interview | <input type="checkbox"/> Yes – List on first available line of listing sheet. Interview if in sample. <input type="checkbox"/> No – Do not interview |
| NOTE: Be sure to continue interview for original unit after completing Table X for all lines. | | | | | | |
| FOOTNOTES | | | | | | |

FORM 100-1 (REV. 10-7-79)

FORM **HIS-2 (1994)**
(4-1-94)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
NATIONAL CENTER FOR HEALTH STATISTICS

NATIONAL HEALTH INTERVIEW SURVEY

1994 SUPPLEMENT BOOKLET

I. IMMUNIZATION

II. DISABILITY

NOTICE - Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to vary from 30 to 40 minutes per response, with an average of 35 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA; Humphrey Building, Room 721-H, 200 Independence Avenue, SW; Washington, DC 20201; and to the Office of Management and Budget, Paperwork Reduction Project (0920-0214) Washington, DC 20503.

2. R.O. number 9-10 3. Sample 11-13 1. Book of books

4. Control number 5. Family number 26

PSU 14-16 Segment 17-23 Serial 24-25

6. Field Representative's name Code 27-29

7. Beginning time 30-33 a.m. p.m. 8. Ending time 35-38 a.m. p.m.

SAMPLE CHILD LIST

ITEM I1

Are there any nondeleted persons under 6 years old in this family?

Yes (List by age, oldest to youngest)
 No (Section II on page 12)

| RT 52 | 3-4 | 5-6 | 7 | | | 8 | 9 | 10 |
|----------|------------|-----|---|-----------|------------|--------------------------|--------------------------|----------|
| Line No. | Person No. | Age | Sex | Last name | First name | SC | 19-35 months | List No. |
| 1 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 2 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 3 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 4 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 5 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 6 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 7 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 8 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |
| 9 | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> | <input type="checkbox"/> | 1 |

Refer to the sample child selection label and circle as applicable. THEN, mark (X) the "SC" box in the column above for the selected sample child under 6.

ITEM I2A

Are there any non-selected 2 year olds in the above list?

Yes (Mark (X) box in "19-35 months" column for EACH, then I2B)
 No (I2B)

ITEM I2B

Are there any non-selected 1 year olds in the above list?

Yes (Refer to Eligibility Chart below for EACH 1 year old)
 No (Section I)

ELIGIBILITY CHART

If month of Interview is: Mark (X) box in "19-35 months" column if child's Date of Birth is Within:

| | |
|----------------|---------------|
| January 1994 | 02/91 - 06/92 |
| February 1994 | 03/91 - 07/92 |
| March 1994 | 04/91 - 08/92 |
| April 1994 | 05/91 - 09/92 |
| May 1994 | 06/91 - 10/92 |
| June 1994 | 07/91 - 11/92 |
| July 1994 | 08/91 - 12/92 |
| August 1994 | 09/91 - 01/93 |
| September 1994 | 10/91 - 02/93 |
| October 1994 | 11/91 - 03/93 |
| November 1994 | 12/91 - 04/93 |
| December 1994 | 01/92 - 05/93 |
| January 1995 | 02/92 - 06/93 |

Complete final status on Back Cover

| | | PERSON 1 | | | | | | |
|---|--|----------------|---|-------------|-----------------------|-----------------------|---|--|
| ITEM X1 Enter conditions reported in the Disability supplement in X1 If insufficient space to enter multiple sources, continue in a footnote | | X1 | | | | | | |
| | | A | C | D | E | F | G | |
| | | A | C | D | E | F | G | |
| | | A | C | D | E | F | G | |
| | | A | C | D | E | F | G | |
| | | A | C | D | E | F | G | |
| ITEM X2 Indicate ADL Limitations in X2 | | X2 | | Help/Remind | Spec. equip. | Difficulty/Doesn't do | | |
| | | Bathing | | | | | | |
| | | Dressing | | | | | | |
| | | Eating | | | | | | |
| | | Bed/chair | | | | | | |
| | | Toilet | | | | | | |
| Getting around | | | | | | | | |
| ITEM X3 Indicate IADL Limitations in X3 | | X3 | | Help/Supv. | Difficulty/Doesn't do | | | |
| | | Prep. meals | | | | | | |
| | | Shopping | | | | | | |
| | | Managing money | | | | | | |
| | | Telephone | | | | | | |
| | | Heavy work | | | | | | |
| Light work | | | | | | | | |
| Notes | | | | | | | | |

Section I - IMMUNIZATION - Continued

| | | | |
|----------------|---|--------------------------------------|--------------|
| ITEM 13 | Enter person number and first name of sample child under 6. | Person number _____ First name _____ | RT 54 3-4 |
| | Enter person number of respondent. | Person number _____ | 5-6 |
| | These questions refer to (read name), and are about immunizations that -- may have received. It would be helpful if we could refer to -- shot record. | | |

| | | | |
|----------------|-----------------------|--|---|
| ITEM 14 | Refer to shot record. | <input type="checkbox"/> Available (2) <input type="checkbox"/> Not available (1) | 7 |
|----------------|-----------------------|--|---|

| | | |
|--|--|---|
| 1. Ask only on initial interview. On callback, skip to 9. We will need the shot record to complete this section of the interview. If I called you within the next few days, would you be able to have --'s shot record available? | <input type="checkbox"/> Yes (Arrange callback, then 15 on page 6) <input type="checkbox"/> No } (9) <input type="checkbox"/> DK } | 8 |
|--|--|---|

2. Transcribe from shot record - If telephone ask: Looking at the shot record, please tell me how many times -- has received (names of vaccines)? Record number of times for each vaccine. What is the date on the record for (first) (vaccine)? Repeat for second, third -- shots.

| | (1) A DTP/DT shot (some times called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three-in-one shot)? | (2) A polio vaccine by mouth (pink drops) or a polio shot? | (3) A measles or MMR (Measles - Mumps - Rubella) shot? If telephone ask: Was each shot measles only or MMR? | | (4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine) | (5) A Hepatitis B shot? |
|------------|---|---|---|------------------------------------|---|--|
| | 9-10 | 59-60 | RT 55 3-4 5-6 | | 35-36 | 61-62 |
| | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | Shots (Record dates, then 3) (Number) 00 <input type="checkbox"/> None } (3) 99 <input type="checkbox"/> DK } |
| | DTP/DT (Shot) | Polio (Drops or shots) | Measles/MMR (Shots) | | HIB (Shot) | Hepatitis B |
| 1st | 11-16 ____/____/19 MO DAY YR | 61-66 ____/____/19 MO DAY YR | <input type="checkbox"/> Measles <input type="checkbox"/> MMR <input type="checkbox"/> DK 7 8-13 | 37-42 ____/____/19 MO DAY YR | 63-68 ____/____/19 MO DAY YR | |
| 2nd | 17-22 ____/____/19 MO DAY YR | 67-72 ____/____/19 MO DAY YR | <input type="checkbox"/> Measles <input type="checkbox"/> MMR <input type="checkbox"/> DK 14 15-20 | 43-48 ____/____/19 MO DAY YR | 69-74 ____/____/19 MO DAY YR | |
| 3rd | 23-28 ____/____/19 MO DAY YR | 73-78 ____/____/19 MO DAY YR | <input type="checkbox"/> Measles <input type="checkbox"/> MMR <input type="checkbox"/> DK 21 22-27 | 49-54 ____/____/19 MO DAY YR | 75-80 ____/____/19 MO DAY YR | |
| 4th | 29-34 ____/____/19 MO DAY YR | 79-84 ____/____/19 MO DAY YR | <input type="checkbox"/> Measles <input type="checkbox"/> MMR <input type="checkbox"/> DK 28 29-34 | 55-60 ____/____/19 MO DAY YR | 81-86 ____/____/19 MO DAY YR | |
| 5th | 35-40 ____/____/19 MO DAY YR | 85-90 ____/____/19 MO DAY YR | | | | |
| 6th | 41-46 ____/____/19 MO DAY YR | 91-96 ____/____/19 MO DAY YR | | | | |
| 7th | 47-52 ____/____/19 MO DAY YR | 97-102 ____/____/19 MO DAY YR | | | | |
| 8th | 53-58 ____/____/19 MO DAY YR | 103-108 ____/____/19 MO DAY YR | | | | |

FORM HIS-2 (4-1-94)

Section I - IMMUNIZATION - Continued

| | | |
|---|---|----|
| 3. Are all the immunizations that -- ever received included on this shot record? | <input type="checkbox"/> Yes (11) <input type="checkbox"/> No } (4) <input type="checkbox"/> DK } | 87 |
| 4a. Has -- ever received an additional DTP shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis shot, baby shot, or three-in-one-shot)? | <input type="checkbox"/> Yes (4b) <input type="checkbox"/> No } (5) <input type="checkbox"/> DK } | 88 |
| b. How many additional DTP shots has -- received? | _____ Shots (Number) <input type="checkbox"/> All <input type="checkbox"/> DK | 89 |
| 5a. Has -- ever received an additional polio vaccine by mouth (pink drops) or a polio shot? | <input type="checkbox"/> Yes (5b) <input type="checkbox"/> No } (6) <input type="checkbox"/> DK } | 90 |
| b. How many additional polio vaccines has -- received? | _____ Vaccines (Number) <input type="checkbox"/> All <input type="checkbox"/> DK | 91 |
| 6a. Has -- ever received an additional measles or MMR (Measles-Mumps-Rubella) shot? | <input type="checkbox"/> Yes (6b) <input type="checkbox"/> No } (7) <input type="checkbox"/> DK } | 92 |
| b. How many additional measles or MMR shots has -- received? | _____ Shots (Number) <input type="checkbox"/> All <input type="checkbox"/> DK | 93 |
| 7a. Has -- ever received an additional Hib shot? This shot is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI), Hib vaccine or H. flu vaccine. | <input type="checkbox"/> Yes (7b) <input type="checkbox"/> No } (8) <input type="checkbox"/> DK } | 94 |
| b. How many additional Hib shots has -- received? | _____ Shots (Number) <input type="checkbox"/> All <input type="checkbox"/> DK | 95 |

Section I - IMMUNIZATION - Continued

| | | |
|--|--|----|
| 8a. Has -- ever received an additional Hepatitis B shot? | 1 <input type="checkbox"/> Yes (8b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (11) | 96 |
| b. How many additional Hepatitis B shots has -- received? | _____ Shots (Number) } (11) 8 <input type="checkbox"/> All 9 <input type="checkbox"/> DK | 97 |

| | | |
|---|---|----|
| 9. Has -- ever received an immunization (that is a shot or drops)? | 1 <input type="checkbox"/> Yes (10) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Item 15 on page 6) | 98 |
|---|---|----|

10a. Has -- ever received:

| | | | | |
|--|---|---|--|--|
| (1) A DTP/DT shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three-in-one shot)? 1 <input type="checkbox"/> Yes (10b) 99 2 <input type="checkbox"/> No } (Next vaccine) 9 <input type="checkbox"/> DK } | (2) A polio vaccine by mouth (pink drops) or a polio shot? 1 <input type="checkbox"/> Yes (10b) 102 2 <input type="checkbox"/> No } (Next vaccine) 9 <input type="checkbox"/> DK } | (3) A measles or MMR (Measles - Mumps - Rubella) shot? 1 <input type="checkbox"/> Yes (10b) 105 2 <input type="checkbox"/> No } (Next vaccine) 9 <input type="checkbox"/> DK } | (4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine) 1 <input type="checkbox"/> Yes (10b) 108 2 <input type="checkbox"/> No } (Next vaccine) 9 <input type="checkbox"/> DK } | (5) A Hepatitis B shot? 1 <input type="checkbox"/> Yes (10b) 111 2 <input type="checkbox"/> No } (11) 9 <input type="checkbox"/> DK } |
|--|---|---|--|--|

10b. How many (vaccine) shots did -- ever receive?

| (1) DTP/DT | (2) Polio | (3) Measles or MMR | (4) HIB | (5) Hepatitis B |
|---|---|---|---|---|
| 100-101 | 103-104 | 106-107 | 109-110 | 112-113 |
| _____ Shots (Number) } (Next vaccine) 88 <input type="checkbox"/> All 99 <input type="checkbox"/> DK | _____ Shots (Number) } (Next vaccine) 88 <input type="checkbox"/> All 99 <input type="checkbox"/> DK | _____ Shots (Number) } (Next vaccine) 88 <input type="checkbox"/> All 99 <input type="checkbox"/> DK | _____ Shots (Number) } (Next vaccine) 88 <input type="checkbox"/> All 99 <input type="checkbox"/> DK | _____ Shots (Number) } (11) 88 <input type="checkbox"/> All 99 <input type="checkbox"/> DK |

| | | |
|--|--|-----|
| 11. Are you the person who took -- for most of -- shots? (Most means at least 1/2 of the shots) | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | 114 |
|--|--|-----|

| | | |
|--|--|-----|
| 12. In your opinion, has -- received all of the recommended shots for -- age? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK | 115 |
|--|--|-----|

Section I - IMMUNIZATION - Continued

| | | | | | | | | | | |
|--|---|---|--|---|--|---|---|--|--|---------------------------|
| ITEM 15 | Refer to Sample Child List on Cover. | 1 <input type="checkbox"/> Additional 19-35 month old child (Item 18 on page 7) 2 <input type="checkbox"/> No additional 19-35 month old child (16) | | | | | | | | |
| ITEM 16 | Refer to questions 2 and 10 for SC. Mark (X) first appropriate box. | 1 <input type="checkbox"/> Callback required } (Fill HIS-2A if appropriate, then 17) 2 <input type="checkbox"/> Any immunizations } 3 <input type="checkbox"/> No immunizations (Section II on page 12) | | | | | | | | |
| ITEM 17 | Status of HIS-2A for SC. Mark (X) one in each column. | <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">Provider</td> <td style="width:50%; text-align: center;">Permission</td> </tr> <tr> <td style="border: none;"> 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) </td> <td style="border: none;"> 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) </td> </tr> </table> </td> <td style="width:50%; border: none; vertical-align: middle;"> <table style="width:100%; border: none;"> <tr> <td style="width:50%;"></td> <td style="width:50%; text-align: center;">} (Section II on page 12)</td> </tr> </table> </td> </tr> </table> | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">Provider</td> <td style="width:50%; text-align: center;">Permission</td> </tr> <tr> <td style="border: none;"> 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) </td> <td style="border: none;"> 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) </td> </tr> </table> | Provider | Permission | 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) | 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) | <table style="width:100%; border: none;"> <tr> <td style="width:50%;"></td> <td style="width:50%; text-align: center;">} (Section II on page 12)</td> </tr> </table> | | } (Section II on page 12) |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">Provider</td> <td style="width:50%; text-align: center;">Permission</td> </tr> <tr> <td style="border: none;"> 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) </td> <td style="border: none;"> 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) </td> </tr> </table> | Provider | Permission | 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) | 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) | <table style="width:100%; border: none;"> <tr> <td style="width:50%;"></td> <td style="width:50%; text-align: center;">} (Section II on page 12)</td> </tr> </table> | | } (Section II on page 12) | | | |
| Provider | Permission | | | | | | | | | |
| 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) | 0 <input type="checkbox"/> Not required 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Refused 3 <input type="checkbox"/> Other (Explain in notes) | | | | | | | | | |
| | } (Section II on page 12) | | | | | | | | | |

| | | |
|-------|--|----------------|
| Notes | | 1 Sample child |
| | | |

Section I - IMMUNIZATION - Continued

RT 54

| | | | |
|----------------|--|--------------------------------------|-----|
| ITEM 18 | Enter person number and first name of other 19-35 month old child. | Person number _____ First name _____ | 3-4 |
| | Enter person number of respondent. | Person number _____ | 5-6 |

These questions refer to (read name), and are about immunizations that -- may have received. It would be helpful if we could refer to -- shot record.

| | | | |
|----------------|-----------------------|---|---|
| ITEM 19 | Refer to shot record. | 1 <input type="checkbox"/> Available (14) | 7 |
| | | 2 <input type="checkbox"/> Not available (13) | |

| | | |
|--|---|---|
| 13. Ask only on initial interview. On callback, skip to 21. We will need the shot record to complete this section of the interview. If I called you within the next few days, would you be able to have --'s shot record available? | 1 <input type="checkbox"/> Yes (Arrange callback, then 110 on page 10) 2 <input type="checkbox"/> No } (21) 9 <input type="checkbox"/> DK } | 8 |
|--|---|---|

14. Transcribe from shot record - If telephone ask: Looking at the shot record, please tell me how many times -- has received (names of vaccines)? Record number of times for each vaccine. What is the date on the record for (first) (vaccine)? Repeat for second, third -- shots.

| | (1) A DTP/DT shot (some times called a DPT shot, diphtheria-tetanus-pertussis-shot, baby shot, or three-in-one shot)? | (2) A polio vaccine by mouth (pink drops) or a polio shot? | (3) A measles or MMR (Measles - Mumps - Rubella) shot? <i>If telephone ask: Was each shot measles only or MMR?</i> | | (4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine) | (5) A Hepatitis B shot? |
|------------|--|--|--|---------------------|---|---|
| | 9-10 | 59-60 | | RT 55 3-4 5-6 | 35-36 | 61-62 |
| | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | | Shots (Record dates) (Number) 00 <input type="checkbox"/> None } (Next vaccine) 99 <input type="checkbox"/> DK } | Shots (Record dates, then 15) (Number) 00 <input type="checkbox"/> None } (15) 99 <input type="checkbox"/> DK } |
| | DTP/DT (Shot) | Polio (Drops or shots) | Measles/MMR (Shots) | | HIB (Shot) | Hepatitis B |
| 1st | 11-16 ____/____/19 MO DAY YR | 61-66 ____/____/19 MO DAY YR | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK ____/____/19 MO DAY YR | 7 8-13 | 37-42 ____/____/19 MO DAY YR | 63-68 ____/____/19 MO DAY YR |
| 2nd | 17-22 ____/____/19 MO DAY YR | 67-72 ____/____/19 MO DAY YR | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK ____/____/19 MO DAY YR | 14 15-20 | 43-48 ____/____/19 MO DAY YR | 69-74 ____/____/19 MO DAY YR |
| 3rd | 23-28 ____/____/19 MO DAY YR | 73-78 ____/____/19 MO DAY YR | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK ____/____/19 MO DAY YR | 21 22-27 | 49-54 ____/____/19 MO DAY YR | 75-80 ____/____/19 MO DAY YR |
| 4th | 29-34 ____/____/19 MO DAY YR | 79-84 ____/____/19 MO DAY YR | 1 <input type="checkbox"/> Measles 2 <input type="checkbox"/> MMR 9 <input type="checkbox"/> DK ____/____/19 MO DAY YR | 28 29-34 | 55-60 ____/____/19 MO DAY YR | 81-86 ____/____/19 MO DAY YR |
| 5th | 35-40 ____/____/19 MO DAY YR | 85-90 ____/____/19 MO DAY YR | | | | |
| 6th | 41-46 ____/____/19 MO DAY YR | 91-96 ____/____/19 MO DAY YR | | | | |
| 7th | 47-52 ____/____/19 MO DAY YR | 97-102 ____/____/19 MO DAY YR | | | | |
| 8th | 53-58 ____/____/19 MO DAY YR | 103-108 ____/____/19 MO DAY YR | | | | |

FORM HIS-2 (4-1-94)

Section I - IMMUNIZATION - Continued

| | | |
|---|--|-------------------------|
| <p>15. Are all the immunizations that -- ever received included on this shot record?</p> | <p>1 <input type="checkbox"/> Yes (23) 2 <input type="checkbox"/> No } (16) 9 <input type="checkbox"/> DK }</p> | <p align="right">87</p> |
| <p>16a. Has -- ever received an additional DTP shot (sometimes called a DPT shot, diphtheria-tetanus-pertussis shot, baby shot, or three-in-one-shot)?</p> | <p>1 <input type="checkbox"/> Yes (16b) 2 <input type="checkbox"/> No } (17) 9 <input type="checkbox"/> DK }</p> | <p align="right">88</p> |
| <p>b. How many additional DTP shots has -- received?</p> | <p>_____ Shots (Number)</p> <p>8 <input type="checkbox"/> All 9 <input type="checkbox"/> DK</p> | <p align="right">89</p> |
| <p>17a. Has -- ever received an additional polio vaccine by mouth (pink drops) or a polio shot?</p> | <p>1 <input type="checkbox"/> Yes (17b) 2 <input type="checkbox"/> No } (18) 9 <input type="checkbox"/> DK }</p> | <p align="right">90</p> |
| <p>b. How many additional polio vaccines has -- received?</p> | <p>_____ Vaccines (Number)</p> <p>8 <input type="checkbox"/> All 9 <input type="checkbox"/> DK</p> | <p align="right">91</p> |
| <p>18a. Has -- ever received an additional measles or MMR (Measles-Mumps-Rubella) shot?</p> | <p>1 <input type="checkbox"/> Yes (18b) 2 <input type="checkbox"/> No } (19) 9 <input type="checkbox"/> DK }</p> | <p align="right">92</p> |
| <p>b. How many additional measles or MMR shots has -- received?</p> | <p>_____ Shots (Number)</p> <p>8 <input type="checkbox"/> All 9 <input type="checkbox"/> DK</p> | <p align="right">93</p> |
| <p>19a. Has -- ever received an additional Hib shot? This shot is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI), Hib vaccine or H. flu vaccine.</p> | <p>1 <input type="checkbox"/> Yes (19b) 2 <input type="checkbox"/> No } (20) 9 <input type="checkbox"/> DK }</p> | <p align="right">94</p> |
| <p>b. How many additional Hib shots has -- received?</p> | <p>_____ Shots (Number)</p> <p>8 <input type="checkbox"/> All 9 <input type="checkbox"/> DK</p> | <p align="right">95</p> |

Section I - IMMUNIZATION - Continued

| | | |
|--|---|----|
| 20a. Has -- ever received an additional Hepatitis B shot? | <input type="checkbox"/> Yes (20b) <input type="checkbox"/> No } (23) <input type="checkbox"/> DK } | 96 |
|--|---|----|

| | | |
|--|---|----|
| b. How many additional Hepatitis B shots has -- received? | _____ Shots (Number) } (23) <input type="checkbox"/> All <input type="checkbox"/> DK | 97 |
|--|---|----|

| | | |
|--|--|----|
| 21. Has -- ever received an immunization (that is a shot or drops)? | <input type="checkbox"/> Yes (22) <input type="checkbox"/> No } (Item 110) <input type="checkbox"/> DK } | 98 |
|--|--|----|

22a. Has -- ever received:

| | | | | |
|--|--|--|---|---|
| (1) A DTP/DT shot (sometimes called a DPT shot, diptheria-tetanus-pertussis-shot, baby shot, or three-in-one shot)? <input type="checkbox"/> Yes (22b) } 99 <input type="checkbox"/> No } (Next vaccine) <input type="checkbox"/> DK } | (2) A polio vaccine by mouth (pink drops) or a polio shot? <input type="checkbox"/> Yes (22b) } 102 <input type="checkbox"/> No } (Next vaccine) <input type="checkbox"/> DK } | (3) A measles or MMR (Measles - Mumps - Rubella) shot? <input type="checkbox"/> Yes (22b) } 105 <input type="checkbox"/> No } (Next vaccine) <input type="checkbox"/> DK } | (4) An HIB shot? (This is for meningitis and called Haemophilus influenzae (HA-MA-FI-LUS IN-FLU-EN-ZI) HIB vaccine or H. flu vaccine) <input type="checkbox"/> Yes (22b) } 108 <input type="checkbox"/> No } (Next vaccine) <input type="checkbox"/> DK } | (5) A Hepatitis B shot? <input type="checkbox"/> Yes (22b) } 111 <input type="checkbox"/> No } (23) <input type="checkbox"/> DK } |
|--|--|--|---|---|

22b. How many (vaccine) shots did -- ever receive?

| (1) DTP/DT | (2) Polio | (3) Measles or MMR | (4) HIB | (5) Hepatitis B |
|---|---|---|---|---|
| 100-101 | 103-104 | 106-107 | 109-110 | 112-113 |
| _____ Shots } (Number) } (Next vaccine) <input type="checkbox"/> All <input type="checkbox"/> DK | _____ Shots } (Number) } (Next vaccine) <input type="checkbox"/> All <input type="checkbox"/> DK | _____ Shots } (Number) } (Next vaccine) <input type="checkbox"/> All <input type="checkbox"/> DK | _____ Shots } (Number) } (Next vaccine) <input type="checkbox"/> All <input type="checkbox"/> DK | _____ Shots } (Number) } (23) <input type="checkbox"/> All <input type="checkbox"/> DK |

| | | |
|--|--|-----|
| 23. Are you the person who took -- for most of -- shots? (Most means at least 1/2 of the shots) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | 114 |
|--|--|-----|

| | | |
|--|--|-----|
| 24. In your opinion, has -- received all of the recommended shots for -- age? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | 115 |
|--|--|-----|

Section I - IMMUNIZATION - Continued

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--|---|--|--------------------------|-------------------------|-----|--|-----------------------------------|--|---------------------------------------|---|--------------------------|--|----------------------------------|--|-----------------------------------|--|---|--|----------------------------------|--|--|--|---|--|--|--|
| ITEM I10 | Refer to questions 14 and 22 for additional 19-35 month old. Mark (X) first appropriate box. | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"></td> <td style="width:15%;"><input type="checkbox"/> Callback required</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Fill HIS-2A, then I11)</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Any immunizations</td> </tr> <tr> <td></td> <td><input type="checkbox"/> No immunizations (Return to I6 on page 6)</td> </tr> </table> | | <input type="checkbox"/> Callback required | } | (Fill HIS-2A, then I11) | | <input type="checkbox"/> Any immunizations | | <input type="checkbox"/> No immunizations (Return to I6 on page 6) | 116 | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Callback required | } | (Fill HIS-2A, then I11) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Any immunizations | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> No immunizations (Return to I6 on page 6) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ITEM I11 | Status of HIS-2A for additional 19-35 month old. Mark (X) one in each column. | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"></td> <td style="width:15%; text-align: center;"><u>Provider</u></td> <td style="width:10%; text-align: center;">117</td> <td style="width:15%; text-align: center;"><u>Permission</u></td> <td style="width:10%; text-align: center;">118</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Complete</td> <td></td> <td><input type="checkbox"/> Not required</td> <td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="3" style="vertical-align: middle;">(Return to I6 on page 6)</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Refused</td> <td></td> <td><input type="checkbox"/> Complete</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other (Explain in notes)</td> <td></td> <td><input type="checkbox"/> Refused</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Other (Explain in notes)</td> <td></td> <td></td> </tr> </table> | | <u>Provider</u> | 117 | <u>Permission</u> | 118 | | <input type="checkbox"/> Complete | | <input type="checkbox"/> Not required | } | (Return to I6 on page 6) | | <input type="checkbox"/> Refused | | <input type="checkbox"/> Complete | | <input type="checkbox"/> Other (Explain in notes) | | <input type="checkbox"/> Refused | | | | <input type="checkbox"/> Other (Explain in notes) | | | |
| | <u>Provider</u> | 117 | <u>Permission</u> | 118 | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Complete | | <input type="checkbox"/> Not required | } | (Return to I6 on page 6) | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Refused | | <input type="checkbox"/> Complete | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Other (Explain in notes) | | <input type="checkbox"/> Refused | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | <input type="checkbox"/> Other (Explain in notes) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes | | 2 Other 19-35 month child | 119 | | | | | | | | | | | | | | | | | | | | | | | | | |

Section II - DISABILITY

RT 65

Part A - SENSORY, COMMUNICATION AND MOBILITY

PERSON 1

3-4

These next questions refer to everyone in the family, that is *(read names of all nondeleted family members)*.

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|----|---|----|--|----|----------------------------------|----|----------------------------------|----|------------------------------------|----|-------------------------------------|----|---|----|--------------------------------|----|
| <p>1a. Does anyone in the family have SERIOUS difficulty seeing, even when wearing glasses or contact lenses?</p> | <p>1a. <input type="checkbox"/> Yes (1b) <input type="checkbox"/> No } (2 on page 14) <input type="checkbox"/> DK } 5</p> | | | | | | | | | | | | | | | | | | |
| <p>b. Who is this? (Anyone else?) <i>Mark (X) "Difficulty seeing" box in person's column.</i></p> | <p>b. <input type="checkbox"/> Difficulty seeing 6</p> | | | | | | | | | | | | | | | | | | |
| <p>c. What is the MAIN problem or condition which causes -- serious difficulty seeing?</p> | <p>c. <i>(Enter condition on X1 and mark box)</i> <input type="checkbox"/> In C2 <input type="checkbox"/> Not in C2 7</p> | | | | | | | | | | | | | | | | | | |
| <p>d. Is -- legally blind?</p> | <p>d. <input type="checkbox"/> Yes (1f) <input type="checkbox"/> No } (1e) <input type="checkbox"/> DK } 8</p> | | | | | | | | | | | | | | | | | | |
| <p>e. [Do you expect/Is -- expected] to have SERIOUS difficulty seeing for at least the next 12 months?</p> | <p>e. <input type="checkbox"/> Yes (1f) <input type="checkbox"/> No } (1c for NP in 1b, or <input type="checkbox"/> DK } 2 on page 14) 9</p> | | | | | | | | | | | | | | | | | | |
| <p>f. Does -- NOW use telescopic lenses, braille, readers, a guide dog, white cane, or any other equipment for people with visual impairments? <i>If "No", mark (X) box 0. If "Yes", ask - "Which?" Mark (X) all that apply.</i></p> | <p>f.</p> <table border="0"> <tr> <td><input type="checkbox"/> Does not use any</td> <td rowspan="7" style="font-size: 3em; vertical-align: middle;">}</td> <td rowspan="7" style="vertical-align: middle;"><i>(1c for NP in 1b, or 2 on page 14)</i></td> <td style="text-align: right;">10</td> </tr> <tr> <td><input type="checkbox"/> Telescopic lenses</td> <td style="text-align: right;">11</td> </tr> <tr> <td><input type="checkbox"/> Braille</td> <td style="text-align: right;">12</td> </tr> <tr> <td><input type="checkbox"/> Readers</td> <td style="text-align: right;">13</td> </tr> <tr> <td><input type="checkbox"/> Guide dog</td> <td style="text-align: right;">14</td> </tr> <tr> <td><input type="checkbox"/> White cane</td> <td style="text-align: right;">15</td> </tr> <tr> <td><input type="checkbox"/> Computer equipment</td> <td style="text-align: right;">16</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td style="text-align: right;">17</td> </tr> </table> | <input type="checkbox"/> Does not use any | } | <i>(1c for NP in 1b, or 2 on page 14)</i> | 10 | <input type="checkbox"/> Telescopic lenses | 11 | <input type="checkbox"/> Braille | 12 | <input type="checkbox"/> Readers | 13 | <input type="checkbox"/> Guide dog | 14 | <input type="checkbox"/> White cane | 15 | <input type="checkbox"/> Computer equipment | 16 | <input type="checkbox"/> Other | 17 |
| <input type="checkbox"/> Does not use any | } | <i>(1c for NP in 1b, or 2 on page 14)</i> | | | 10 | | | | | | | | | | | | | | |
| <input type="checkbox"/> Telescopic lenses | | | | | 11 | | | | | | | | | | | | | | |
| <input type="checkbox"/> Braille | | | | | 12 | | | | | | | | | | | | | | |
| <input type="checkbox"/> Readers | | | | | 13 | | | | | | | | | | | | | | |
| <input type="checkbox"/> Guide dog | | | | | 14 | | | | | | | | | | | | | | |
| <input type="checkbox"/> White cane | | | | | 15 | | | | | | | | | | | | | | |
| <input type="checkbox"/> Computer equipment | | | 16 | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other | 17 | | | | | | | | | | | | | | | | | | |

Notes

Section II – DISABILITY – Continued

Part A – SENSORY, COMMUNICATION AND MOBILITY – Continued

PERSON 1

| | |
|---|--|
| <p>2a. Does anyone in the family now use a hearing aid?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Hearing aid" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (<i>Reask 2b and c</i>) <input type="checkbox"/> No (<i>2d</i>)</p> <p>-----</p> <p>d. Does anyone in the family have any trouble hearing what is said in normal conversation (even when wearing a hearing aid)?</p> <p>-----</p> <p>e. Who is this? (Anyone else?) <i>Mark (X) "Trouble hearing" box in person's column.</i> <i>Ask 2f-h and 3 for each person with box marked in 2e.</i></p> <p>-----</p> <p>f. What is the MAIN problem or condition which causes -- to have trouble hearing?</p> <p>-----</p> <p>g. Is -- able to hear loud noises?</p> <p>-----</p> <p>h. [Do you expect/Is -- expected] to have this trouble hearing for at least the next 12 months?</p> | <p>2a. 18</p> <p>1 <input type="checkbox"/> Yes (<i>2b</i>) 2 <input type="checkbox"/> No } (<i>2d</i>) 9 <input type="checkbox"/> DK }</p> <p>b. 19</p> <p>1 <input type="checkbox"/> Hearing aid</p> <p>d. 20</p> <p>1 <input type="checkbox"/> Yes (<i>2e</i>) 2 <input type="checkbox"/> No } (<i>4 on page 16</i>) 9 <input type="checkbox"/> DK }</p> <p>e. 21</p> <p>1 <input type="checkbox"/> Trouble hearing</p> <p>f. 22</p> <p>(<i>Enter condition in X1 and mark box</i>) 1 <input type="checkbox"/> In C2 2 <input type="checkbox"/> Not in C2</p> <p>g. 23</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>h. 24</p> <p>1 <input type="checkbox"/> Yes (<i>3</i>) 2 <input type="checkbox"/> No } (<i>2f for NP in 2e, or</i> 9 <input type="checkbox"/> DK } <i>4 on page 16</i>)</p> <p>3.</p> <p>0 <input type="checkbox"/> Does not use any 25 1 <input type="checkbox"/> Amplifier for 26 telephone 2 <input type="checkbox"/> TDD, TTY, or teletype 27 3 <input type="checkbox"/> Closed caption TV 28 4 <input type="checkbox"/> Assistive listening 29 devices 5 <input type="checkbox"/> Assistive signaling 30 devices 6 <input type="checkbox"/> Interpreter 31 7 <input type="checkbox"/> Other 32</p> <p>(<i>2f for NP in 2e, or 4 on page 16</i>)</p> |
| <p>3. (Besides a hearing aid,) Does -- NOW use an amplifier for the telephone, a TDD, TTY or teletype, closed caption TV, assistive listening or signaling devices, an interpreter, or any other equipment for people with hearing impairments?</p> <p><i>Read if necessary: Assistive listening devices include a loop, FM systems, and direct input devices that connect to a TV. Assistive signaling devices indicate that a door, telephone or fire bells are ringing.</i></p> <p><i>If "No", mark (X) box 0.</i> <i>If "Yes", ask "Which"? Mark (X) all that apply.</i></p> | |

Section II - DISABILITY - Continued

Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued

PERSON 1

The next few questions refer only to family members who are 5 years old or older, that is (read names of family members 5 years old or older).

33

4a. Do (read names of persons 5+) have SERIOUS difficulty communicating so that PEOPLE OUTSIDE THE FAMILY understand?

- 4a.** 1 Yes (4b)
 2 No } (4f)
 9 DK }

Read if necessary: Do not include language problems.

b. Who is this?

Mark (X) "Difficulty communicating" box in person's column.

- b.** 1 Difficulty communicating

34

c. Anyone else?

- Yes (Reask 4b and c) No

Ask 4d-e for each person with "Difficulty communicating" marked in 4b.

d. Does -- have any difficulty communicating so that FAMILY MEMBERS understand?

- d.** 1 Yes (4e)
 2 No } (NP in 4b, or 4f)
 9 DK }

35

e. Does -- have difficulty communicating -- basic needs, such as hunger and thirst, to family members?

- e.** 1 Yes } (4d for NP in 4b, or 4f)
 2 No }
 9 DK }

36

f. Do (read names of persons 5+) have SERIOUS difficulty understanding other people when they talk or ask questions?

Read if necessary: Do not include language problems.

- f.** 1 Yes (4g)
 2 No } (A1)
 9 DK }

37

g. Who is this?

Mark (X) "Difficulty understanding" box in person's column.

- g.** 1 Difficulty understanding

38

h. Anyone else?

- Yes (Reask 4g and h) No (A1)

**ITEM
A1**

Refer to age or questions 4b and 4g for each person.

- A1** 2 Under 5 (NP, or 4n on page 18)
 1 "Difficulty communicating" in 4b and/or "Difficulty understanding" in 4g (4i on page 18)
 2 All others (NP, or 4n on page 18)

39

Notes

Section II - DISABILITY - Continued

Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued

PERSON 1

| | |
|--|---|
| <p>4i. How old was -- when -- first had difficulty [communicating with/(and) understanding] other people?</p> <p>-----</p> <p>j. Was it before -- was 18 years old?</p> <p>-----</p> <p>k. Was it before -- was 22 years old?</p> <p>-----</p> <p><i>If obvious, mark without asking; otherwise ask:</i></p> <p>l. Is -- expected to have this difficulty with [communication/(and) understanding other people] for at least 12 months longer?</p> <p>-----</p> <p>m. What condition causes -- difficulty [communicating with/(and) understanding] other people?</p> <p><i>Accept up to 2 conditions; then go to A1 on page 16 for next person, or 4n.</i></p> <p>-----</p> | <p>4i. _____ Years old (4i) 40-41 96 <input type="checkbox"/> At birth (4i) 99 <input type="checkbox"/> DK (4j)</p> <p>j. 42 1 <input type="checkbox"/> Yes (4i) 2 <input type="checkbox"/> No (4k) 9 <input type="checkbox"/> DK (4l)</p> <p>k. 43 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (4l) 9 <input type="checkbox"/> DK</p> <p>l. 44 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No } (4m) 9 <input type="checkbox"/> DK</p> <p>m. 45 (Enter condition in X1 and mark box) 1 <input type="checkbox"/> In C2 2 <input type="checkbox"/> Not in C2</p> <p>46 (Enter condition in X1 and mark box) 1 <input type="checkbox"/> In C2 2 <input type="checkbox"/> Not in C2</p> <p>n. 47 1 <input type="checkbox"/> Yes (4o) 2 <input type="checkbox"/> No } (5 on page 20) 9 <input type="checkbox"/> DK</p> <p>o. 48 1 <input type="checkbox"/> Difficulty learning</p> |
| <p>n. Do (read names of persons 5+) have SERIOUS difficulty learning how to do things that most people their age are able to learn?</p> <p>-----</p> <p>o. Who is this?</p> <p><i>Mark (X) "Difficulty learning" box in person's column.</i></p> <p>-----</p> <p>p. Anyone else?</p> <p align="center"> <input type="checkbox"/> Yes (Reask 4o and p) <input type="checkbox"/> No (5 on page 20) </p> | |

Notes

Section II - DISABILITY - Continued

Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued

PERSON 1

HAND CARD DA1. Read parenthetical if telephone interview.

49

5a. Does ANYONE in the family now use any of these aids to get around? (A cane, crutches, walker, medically prescribed shoes, a wheelchair, or a scooter?)

- 5a.** 1 Yes (5b)
 2 No } (6 on page 22)
 9 DK }

b. Who is this?

Mark (X) "Mobility aid" box in person's column.

- b.** 1 Mobility aid 50

c. Anyone else?

- Yes (Reask 5b and c) No

Ask 5d and e for each person with "Mobility aid" in 5b.

d. Which aids does -- use?

Any others?

Mark (X) all that apply.

If "wheelchair", ask: **Does -- use an electric or manual wheelchair?**

- d.** 1 Cane 51
 2 Crutches 52
 3 Walker 53
 4 Medically prescribed shoes 54
 5 Manual wheelchair 55
 6 Electric wheelchair 56
 7 Scooter 57

Ask only about each aid marked in 5d. Then 5d for next person with 5b; otherwise 6 on page 22.

58

e. Has -- used or is -- expected to use (aid in 5d) for 12 months or longer?

(1) A cane

- (1)** 1 Yes 2 No 9 DK 59

(2) Crutches

- (2)** 1 Yes 2 No 9 DK 60

(3) A walker

- (3)** 1 Yes 2 No 9 DK 61

(4) Medically prescribed shoes

- (4)** 1 Yes 2 No 9 DK 62

(5) A manual wheelchair

- (5)** 1 Yes 2 No 9 DK 63

(6) An electric wheelchair

- (6)** 1 Yes 2 No 9 DK 64

(7) A scooter

- (7)** 1 Yes 2 No 9 DK

Notes

Section II - DISABILITY - Continued

Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued

PERSON 1

6a. Does anyone in the family now use a brace of any kind?

6a.

- 1 Yes (6b)
- 2 No } (7)
- 9 DK }

65

b. Who is this?

Ask if necessary: On what part of the body is the brace worn? Is it worn on the back, neck, arm, hand, leg, foot or knee?

Mark (X) appropriate box(es) in person's column.

b.

- 1 Back
- 2 Neck
- 3 Arm
- 4 Hand
- 5 Leg
- 6 Foot
- 7 Knee
- 8 Other

66
67
68
69
70
71
72
73

c. Does anyone else now use a brace?

- Yes (Reask 6b and c) No

Ask 6d for each person with an entry in 6b.

d.

- 1 Yes } (6d for NP with entry in 6b, or 7)
- 2 No }
- 9 DK }

74

7a. (Does anyone in the family now use) an artificial leg, foot, arm or hand?

7a.

- 1 Yes (7b)
- 2 No } (A2 on page 24)
- 9 DK }

75

b. Who is this?

Ask if necessary: Which does -- use -- an artificial leg, foot, arm or hand?

Mark (X) appropriate box(es) in person's column.

b.

- 1 Artificial leg or foot
- 2 Artificial arm or hand

76
77

c. Does anyone else now use an artificial limb?

- Yes (Reask 7b and c) No (A2 on page 24)

Notes

Section II - DISABILITY - Continued

Part A - SENSORY, COMMUNICATION AND MOBILITY - Continued

PERSON 1

| | | | | |
|---|---|------------|---|----|
| ITEM A2 | <i>Refer to ages of ALL family members.</i> | A2 | 1 <input type="checkbox"/> All under 18 (Part B on page 28) 2 <input type="checkbox"/> Any 18+ (8) | 78 |
| 8a. Do (names of persons 18+) now have any problem with dizziness that has lasted for at least three months? | | 8a. | 1 <input type="checkbox"/> Yes (8b) 2 <input type="checkbox"/> No } (8d) 9 <input type="checkbox"/> DK } | 79 |
| b. Who is this? <i>Mark (X) "Dizziness" box in person's column.</i> | | b. | 1 <input type="checkbox"/> Dizziness | 80 |
| c. Anyone else? <input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No (8d) | | | | |
| d. Do (names of persons 18+) have any problem with balance that has lasted for at least three months? | | d. | 1 <input type="checkbox"/> Yes (8e) 2 <input type="checkbox"/> No } (9) 9 <input type="checkbox"/> DK } | 81 |
| e. Who is this? <i>Mark (X) "Problem with balance" box in person's column.</i> | | e. | 1 <input type="checkbox"/> Problem with balance | 82 |
| f. Anyone else? <input type="checkbox"/> Yes (Reask 8e and f) <input type="checkbox"/> No | | | | |
| <i>Ask 8g for each person with "Problem with balance" marked in 8e.</i> | | | | 83 |
| g. Does -- need support or touch walls when walking due to balance problems? | | g. | 1 <input type="checkbox"/> Yes } (NP in 8e, or 9) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } | |
| 9a. Do (names of persons 18+) now have ringing, roaring, or buzzing in the ears that has lasted for at least three months? | | 9a. | 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No } (10 on page 26) 9 <input type="checkbox"/> DK } | 84 |
| b. Who is this? <i>Mark (X) "Noise in ears" box in person's column.</i> | | b. | 1 <input type="checkbox"/> Noise in ears | 85 |
| c. Anyone else? <input type="checkbox"/> Yes (Reask 9b and c) <input type="checkbox"/> No (10 on page 26) | | | | |
| Notes | | | | |

Section II – DISABILITY – Continued

Part A – SENSORY, COMMUNICATION AND MOBILITY – Continued

PERSON 1

| | |
|---|--|
| <p>10a. Do (names of persons 18+) now have any problems with their sense of smell, such as not being able to smell things or things not smelling the way they are supposed to?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Problem with smell" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (<i>Reask 10b and c</i>) <input type="checkbox"/> No <i>Ask 10d-f for each person with box marked in 10b.</i></p> <p>-----</p> <p>d. Which problem does -- have, not being able to smell things or things not smelling the way they are supposed to?</p> <p>-----</p> <p>e. Is -- loss of smell complete or partial?</p> <p>-----</p> <p>f. Has -- had problems with -- sense of smell for at least three months?</p> | <p>10a. 86 1 <input type="checkbox"/> Yes (<i>10b</i>) 2 <input type="checkbox"/> No } (<i>11</i>) 9 <input type="checkbox"/> DK</p> <hr/> <p>b. 87 1 <input type="checkbox"/> Problem with smell</p> <hr/> <p>d. 88 1 <input type="checkbox"/> Loss of smell (<i>10e</i>) 2 <input type="checkbox"/> Things don't smell right } (<i>10f</i>) 9 <input type="checkbox"/> DK</p> <hr/> <p>e. 89 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Partial 9 <input type="checkbox"/> DK</p> <hr/> <p>f. 90 1 <input type="checkbox"/> Yes } (<i>10d for NP in 10b,</i> 2 <input type="checkbox"/> No } <i>or 11</i>) 9 <input type="checkbox"/> DK</p> |
| <p>11a. Do (names of persons 18+) have a problem with their sense of taste, such as not being able to taste salt or sugar or with tastes in the mouth that shouldn't be there, like bitter, salty, sour or sweet tastes?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Problem with taste" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (<i>Reask 11b and c</i>) <input type="checkbox"/> No <i>Ask 11d-e for each person with box marked in 11b.</i></p> <p>-----</p> <p>d. Which problem does -- have, not being able to taste salt or sugar, tastes in the mouth that shouldn't be there, or some other problem? <i>Mark (X) all that apply.</i></p> <p>-----</p> <p>e. Has -- had [any of these/this] problem(s) with taste for at least three months?</p> | <p>11a. 91 1 <input type="checkbox"/> Yes (<i>11b</i>) 2 <input type="checkbox"/> No } (<i>Part B on page 28</i>) 9 <input type="checkbox"/> DK</p> <hr/> <p>b. 92 1 <input type="checkbox"/> Problem with taste</p> <hr/> <p>d. 93 1 <input type="checkbox"/> Not tasting salt 94 2 <input type="checkbox"/> Not tasting sugar 95 3 <input type="checkbox"/> Tastes that shouldn't be there 96 4 <input type="checkbox"/> Other problem</p> <hr/> <p>e. 97 1 <input type="checkbox"/> Yes } (<i>11d for NP in 11b,</i> 2 <input type="checkbox"/> No } <i>or Part B on page 28</i>) 9 <input type="checkbox"/> DK</p> |

Section II - DISABILITY - Continued

RT 66

Part B - CONDITIONS

PERSON 1

3-4

(I am going to read a list of medical conditions. Tell me if anyone in the family has any of these conditions, even if you have mentioned them before.)

1a. Does anyone in the family, that is (read names) have -

1a.

(1) **A learning disability?**

1 Yes(1b) 2 No 9 DK 5

(2) **Cerebral palsy** (cĕ Rĕ' brăi pawl'zee)?

1 Yes(1b) 2 No 9 DK 6

(3) **Cystic fibrosis** (sis'tic fī brō'sis)?

1 Yes(1b) 2 No 9 DK 7

(4) **Down syndrome?**

1 Yes(1b) 2 No 9 DK 8

(5) **Mental retardation?**

1 Yes(1b) 2 No 9 DK 9

(6) **Muscular dystrophy** (dis' trō fee)?

1 Yes(1b) 2 No 9 DK 10

(7) **Spina bifida** (spīn' ah bif ī dah)?

1 Yes(1b) 2 No 9 DK 11

(8) **Autism** (aw'tizm)?

1 Yes(1b) 2 No 9 DK 12

(9) **Hydrocephalus** (hī drō sef'ah lūs)?

1 Yes(1b) 2 No(2) 9 DK(2) 13

b. Who is this?

Mark (X) appropriate box in person's column.

b.

- 1 Learning disability 14
- 2 Cerebral Palsy 15
- 3 Cystic Fibrosis 16
- 4 Down Syndrome 17
- 5 Mental Retardation 18
- 6 Muscular Dystrophy 19
- 7 Spina Bifida 20
- 8 Autism 21
- 9 Hydrocephalus 22

c. Anyone else?

If "Yes" (Reask 1b and c)

If "No" (1a for NC, or 2)

2a. Was anyone in the family EVER told by a doctor that they had polio, whether or not it resulted in physical disability?

2a.

1 Yes (2b) 23
 2 No } (Part C on page 30)
 9 DK }

b. Who is this? (Anyone else?)

Mark (X) "Polio" box in person's column.

Ask 2c for each person with "Polio" box marked in 2b.

b.

1 Polio 24

c. Did -- EVER have paralysis of any kind caused by polio?

c.

1 Yes 25
 2 No
 9 DK

Section II - DISABILITY - Continued

RT 67

Part C - ADL / IADL

PERSON 1

3-4

HAND CARD DC1.

These next questions refer only to *(read names of persons 5+)*.

1a. Because of a physical, mental, or emotional problem, do *(read names of persons 5+)* GET HELP FROM ANOTHER PERSON in --

(1) Bathing or showering?

1 Yes(1b) 2 No 9 DK

5

(2) Dressing?

1 Yes(1b) 2 No 9 DK

6

(3) Eating?

1 Yes(1b) 2 No 9 DK

7

(4) Getting in and out of bed or chairs?

1 Yes(1b) 2 No 9 DK

8

(5) Using the toilet, including getting to the toilet?

1 Yes(1b) 2 No 9 DK

9

(6) Getting around inside the home?

1 Yes(1b) 2 No(2) 9 DK(2)

10

b. Who is this? (Anyone else?)

Mark (X) appropriate box in person's column AND in "Help/Remind" column in X2, then continue with 1a for next activity, or 2.

- b.**
- 1 Bathing or showering 11
 - 2 Dressing 12
 - 3 Eating 13
 - 4 Getting in/out bed or chairs 14
 - 5 Using the toilet, including getting to the toilet 15
 - 6 Getting around inside the home 16
- (Mark (X) appropriate box(es) in X2)

Refer to Card DC1. Read all categories in 2c if telephone interview.

2a. Because of a physical, mental, or emotional problem, do *(read names of persons 5+)* need to be reminded to do [any of these/any of the following] activities, or need to have someone close by when they do them?

b. Who is this? (Anyone else?)

Mark (X) "Remind/close" box in person's column.

Ask 2c for each person with "Remind/close" in 2b, then 3 on page 32.

Refer to Card DC1. Read each category if telephone interview.

c. For which activities does -- need to be reminded or to have someone close by? (Any others?)

Mark (X) all that apply in person's column AND in "Help/Remind" column in X2.

2a.

- 1 Yes (2b)
- 2 No } (3 on page 32)
- 9 DK

17

b.

- 1 Remind/close

18

- c.**
- 1 Bathing or showering 19
 - 2 Dressing 20
 - 3 Eating 21
 - 4 Getting in/out bed or chairs 22
 - 5 Using the toilet, including getting to the toilet 23
 - 6 Getting around inside the home 24
- (Mark (X) appropriate box(es) in X2)

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

PERSON 1

Refer to Card DC1. Read all categories in 3c if telephone interview.

3a. Do (read names of persons 5+) use any SPECIAL EQUIPMENT to do any of [these/the following] activities?

- 3a.** 1 Yes (3b)
 2 No } (Item C1)
 9 DK

25

b. Who is this? (Anyone else?)

Mark (X) "Equipment" box in person's column.

Ask 3c for each person with "Equipment" in 3b, then go to C1.

Refer to Card DC1. Read each category if telephone interview.

c. For which activities does -- use special equipment? (Any others?)

Mark (X) all that apply in person's column AND in "Spec. Equip." column in X2.

- b.** 1 Equipment

26

- c.** 1 Bathing or showering
 2 Dressing
 3 Eating
 4 Getting in/out bed or chairs
 5 Using the toilet, including getting to the toilet
 6 Getting around inside the home

27

28

29

30

31

32

(Mark (X) appropriate box(es) in X2)

ITEM C1

Refer to age and Item X2. Mark (X) first appropriate box.

C1

- 0 Under 5 (NP, or C2 on page 38)
 1 One or more activities marked in X2 (4)
 2 No activities in X2 (5 on page 36)

33

Mark (X) box 0 or ask:

4a. Does -- have any difficulty bathing?

If doesn't do, Ask: **Is this because of a physical, mental, or emotional problem?**

If "Yes", mark (X) box 3 "Doesn't do/health"
 If "No", mark (X) box 2 "No"

- 4a.** 0 Bathing in X2 (4c)
 1 Yes (Mark X2 then 4b)
 2 No (4c)
 3 Doesn't do/health (Mark X2, then 4c)
 9 DK (4c)

34

b. How much difficulty does -- have bathing -- some, a lot, or is -- unable to do it?

- b.** 1 Some
 2 A lot
 3 Unable
 9 DK

35

Mark (X) box 0 or ask:

c. Does -- have any difficulty dressing?

If doesn't do, Ask: **Is this because of a physical, mental, or emotional problem?**

If "Yes", mark (X) box 3 "Doesn't do/health"
 If "No", mark (X) box 2 "No"

- c.** 0 Dressing in X2 (4e on page 34)
 1 Yes (Mark X2 then 4d on page 34)
 2 No (4e on page 34)
 3 Doesn't do/health (Mark X2, then 4e on page 34)
 9 DK (4e on page 34)

36

Section II - DISABILITY - Continued

Part C - ADL / IADL-Continued

PERSON 1

4d. How much difficulty does -- have dressing -- some, a lot, or is -- unable to do it?

- 4d.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK

37

 Mark (X) box 0 or ask:

e. Does -- have any difficulty eating?

If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
 If "No", mark (X) box 2 "No"*

- e.**
- 0 Eating in X2 (4g)
 - 1 Yes (Mark X2 then 4f)
 - 2 No (4g)
 - 3 Doesn't do/health (Mark X2, then 4g)
 - 9 DK (4g)

38

f. How much difficulty does -- have eating -- some, a lot, or is -- unable to do it?

- f.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK

39

 Mark (X) box 0 or ask:

g. Does -- have any difficulty getting in and out of bed or chairs?

If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
 If "No", mark (X) box 2 "No"*

- g.**
- 0 Bed/Chair in X2 (4i)
 - 1 Yes (Mark X2 then 4h)
 - 2 No (4i)
 - 3 Doesn't do/health (Mark X2, then 4i)
 - 9 DK (4i)

40

h. How much difficulty does -- have getting in and out of beds or chairs -- some, a lot, or is -- unable to do it?

- h.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK

41

 Mark (X) box 0 or ask:

i. Does -- have any difficulty using the toilet, including getting to the toilet?

If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
 If "No", mark (X) box 2 "No"*

- i.**
- 0 Toilet in X2 (4k on page 36)
 - 1 Yes (Mark X2 then 4j)
 - 2 No (4k on page 36)
 - 3 Doesn't do/health (Mark X2, then 4k on page 36)
 - 9 DK (4k on page 36)

42

j. How much difficulty does -- have using the toilet, including getting to the toilet -- some, a lot, or is -- unable to do it?

- j.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK
- } (4k on page 36)

43

Section II – DISABILITY – Continued

Part C – ADL / IADL – Continued

PERSON 1

Mark (X) box 0 or ask:

4k. Does -- have any difficulty getting around inside the home?

If doesn't do, Ask: Is this because of a physical, mental, or emotional problem?

If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"

l. How much difficulty does -- have getting around inside the home -- some, a lot, or is -- unable to do it?

- 4k.** 0 Getting around in X2 (C1 on page 32 for NP, or C2 on page 38) **44**
 1 Yes (Mark X2 then 4l)
 2 No (C1 on page 32 for NP, or C2 on page 38)
 3 Doesn't do/health (Mark X2, then C1 on page 32 for NP, or C2 on page 38)
 9 DK (C1 on page 32 for NP, or C2 on page 38)

- l.** 1 Some } (C1 on page 32 for NP, or C2 on page 38) **45**
 2 A lot
 3 Unable
 9 DK

HAND CARD DC1. Read categories if telephone interview.

5a. Because of a physical, mental, or emotional problem, does -- have any difficulty with any of [these/the following] activities?

If "Yes", ask "Which"? and mark the appropriate box(es) in person's column AND in "Difficulty/Doesn't do" column in X2.

If doesn't do, ask: Is this because of a physical, mental, or emotional problem?

If "Yes", mark (X) box for that activity
If "No", do not mark the box for that activity

Mark (X) box 0 only if no other boxes are marked.

Ask only if box 1 "Bathing" in 5a; otherwise, skip to 5c.

b. How much difficulty does -- have bathing or showering -- some, a lot, or is -- unable to do it?

Ask only if box 2 "Dressing" in 5a; otherwise, skip to 5d.

c. How much difficulty does -- have dressing -- some, a lot, or is -- unable to do it?

Ask only if box 3 "Eating" in 5a; otherwise, skip to 5e.

d. How much difficulty does -- have eating -- some, a lot, or is -- unable to do it?

Ask only if box 4 "Getting in/out bed or chairs" in 5a; otherwise, skip to 5f on page 38.

e. How much difficulty does -- have getting in and out of bed or chairs -- some, a lot, or is -- unable to do it?

- 5a.** 0 No difficulty (C1 on page 32 for NP, or C2 on page 38) **46**
 1 Bathing or showering **47**
 2 Dressing **48**
 3 Eating **49**
 4 Getting in/out bed or chairs **50**
 5 Using the toilet, including getting to the toilet **51**
 6 Getting around inside the home **52**

Mark (X) appropriate box(es) in X2

- b.** 1 Some
 2 A lot
 3 Unable
 9 DK **53**

- c.** 1 Some **54**
 2 A lot
 3 Unable
 9 DK

- d.** 1 Some **55**
 2 A lot
 3 Unable
 9 DK

- e.** 1 Some } (5f on page 38) **56**
 2 A lot
 3 Unable
 9 DK

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

PERSON 1

Ask only if box 5 "Using the toilet" in 5a; otherwise, skip to 5g.

5f. How much difficulty does -- have using the toilet, including getting to the toilet -- some, a lot, or is -- unable to do it?

- 5f.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK

57

Ask only if box 6 "Getting around inside" in 5a; otherwise, go to C1 on page 32 for NP, or C2.

g. How much difficulty does -- have getting around inside the home -- some, a lot, or is -- unable to do it?

- g.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK
- } (C1 on page 32 for NP, or C2)

58

**ITEM
C2**

Refer to age and item X2. Mark (X) first appropriate box.

C2

- 0 Under 5 (NP, or 10 on page 56)
- 1 One or more activities marked in X2 (ADL table)
- 2 No activities in X2 (NP, or 10 on page 56)

59

If no more persons in family, skip to 10 on page 56.

Notes

Section II - DISABILITY - Continued

RT 68

Part C - ADL / IADL - Continued

ADL TABLE 1

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|---|---|--|---|---|----|--|--|--|--|---|--|----|---|----|---|--|----|---|----|----|--|--|---|--|--|---|--|--|--|--|--|--|---|--|--|-------|--|--|--|--|
| ITEM C3 | Enter person's number and name. | C3 | Person number _____ Name _____ | 3-4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ITEM C4 | Refer to X2 for this person. Mark (X) first appropriate box. | C4 | 1 <input type="checkbox"/> "Help/Remind" (6) 2 <input type="checkbox"/> "Special equip." (7) 3 <input type="checkbox"/> "Difficulty/doesn't do" (8 on page 42) | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6a. You said that -- gets help, needs to be reminded, or needs someone close by when (activities with "help/remind" in X2). Who gives this help? Anyone else? Mark (X) all that apply. If ONLY help is from spouse/child(ren)/parent, mark (X) box 0; otherwise, ask: b. Is any of this help paid for? ----- c. Which helpers are paid? Anyone else? Mark (X) all the apply. | | 6a. Household members <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-bottom: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">1 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">6</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">7</td> </tr> </table> </td> <td style="width:50%; border-bottom: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">3 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">8</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">9</td> </tr> </table> </td> </tr> <tr> <td colspan="2" style="border-top: 1px dashed black;"> b. 0 <input type="checkbox"/> Spouse/child(ren)/parent only (7) 1 <input type="checkbox"/> Yes (6c) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (7) </td> <td colspan="2" style="border-top: 1px dashed black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-bottom: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">1 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">11</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">12</td> </tr> </table> </td> <td style="width:50%; border-bottom: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">3 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">13</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">14</td> </tr> </table> </td> </tr> </table> </td> <td style="text-align:center;">10</td> </tr> <tr> <td colspan="2" style="border-top: 1px dashed black;"> Ask 7a and b only if "Help/remind" and/or "Special equip." for Bathing; otherwise, skip to 7c. </td> <td colspan="3" style="border-top: 1px dashed black;"> Ask 7c and d only if "Help/remind" and/or "Special equip." for Dressing; otherwise, skip to 7e. </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> 7a. If -- did not (get help from another person/(and) use special equipment), how much difficulty would -- have bathing -- some, a lot, or would -- be completely unable to do this? 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK </td> <td colspan="3" style="vertical-align: top;"> 7c. If -- did not (get help from another person/(and) use special equipment), how much difficulty would -- have dressing -- some, a lot, or would -- be completely unable to do this? 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK </td> </tr> <tr> <td colspan="2" style="border-top: 1px dashed black;"> b. WITH [help from another person/(and) special equipment], how much difficulty does -- have bathing -- some, a lot, or is -- completely unable to do this? 0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable </td> <td colspan="3" style="border-top: 1px dashed black;"> d. WITH [help from another person/(and) special equipment], how much difficulty does -- have dressing -- some, a lot, or is -- completely unable to do this? 0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable </td> </tr> <tr> <td colspan="5" style="height: 100px; vertical-align: top;">Notes</td> </tr> </table> | | | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">1 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">6</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">7</td> </tr> </table> | 1 <input type="checkbox"/> Relative(s) | 6 | 2 <input type="checkbox"/> Nonrelative(s) | 7 | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">3 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">8</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">9</td> </tr> </table> | 3 <input type="checkbox"/> Relative(s) | 8 | 4 <input type="checkbox"/> Nonrelative(s) | 9 | b. 0 <input type="checkbox"/> Spouse/child(ren)/parent only (7) 1 <input type="checkbox"/> Yes (6c) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (7) | | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-bottom: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">1 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">11</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">12</td> </tr> </table> </td> <td style="width:50%; border-bottom: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">3 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">13</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">14</td> </tr> </table> </td> </tr> </table> | | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">1 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">11</td> </tr> <tr> <td>2 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">12</td> </tr> </table> | 1 <input type="checkbox"/> Relative(s) | 11 | 2 <input type="checkbox"/> Nonrelative(s) | 12 | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:100px;">3 <input type="checkbox"/> Relative(s)</td> <td style="width:50px; text-align:center;">13</td> </tr> <tr> <td>4 <input type="checkbox"/> Nonrelative(s)</td> <td style="text-align:center;">14</td> </tr> </table> | 3 <input type="checkbox"/> Relative(s) | 13 | 4 <input type="checkbox"/> Nonrelative(s) | 14 | 10 | Ask 7a and b only if "Help/remind" and/or "Special equip." for Bathing ; otherwise, skip to 7c. | | Ask 7c and d only if "Help/remind" and/or "Special equip." for Dressing ; otherwise, skip to 7e. | | | 7a. 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| 2 <input type="checkbox"/> Nonrelative(s) | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Relative(s) | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> Nonrelative(s) | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1 <input type="checkbox"/> Relative(s) | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> Nonrelative(s) | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Relative(s) | 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> Nonrelative(s) | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ask 7a and b only if "Help/remind" and/or "Special equip." for Bathing ; otherwise, skip to 7c. | | Ask 7c and d only if "Help/remind" and/or "Special equip." for Dressing ; otherwise, skip to 7e. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. If -- did not (get help from another person/(and) use special equipment), how much difficulty would -- have bathing -- some, a lot, or would -- be completely unable to do this? 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK | | 7c. If -- did not (get help from another person/(and) use special equipment), how much difficulty would -- have dressing -- some, a lot, or would -- be completely unable to do this? 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. WITH [help from another person/(and) special equipment], how much difficulty does -- have bathing -- some, a lot, or is -- completely unable to do this? 0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable | | d. WITH [help from another person/(and) special equipment], how much difficulty does -- have dressing -- some, a lot, or is -- completely unable to do this? 0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

ADL TABLE 1 - Continued

Ask 7e and f only if "Help/remind" and/or "Special equip." for **Eating**; otherwise, skip to 7g. 19

7e. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have eating -- some, a lot, or would -- be completely unable to do this?

- 1 Some 3 Completely unable
2 A lot 9 DK

f. WITH [help from another person/(and) special equipment] how much difficulty does -- have eating -- some, a lot, or is -- completely unable to do this? 20

- 0 No difficulty 2 A lot 9 DK
1 Some 3 Completely unable

Ask 7g and h only if "Help/remind" and/or "Special equip." for **Bed or chair**; otherwise, skip to 7i. 21

g. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have getting in and out of bed or chairs -- some, a lot, or would -- be completely unable to do this?

- 1 Some 3 Completely unable
2 A lot 9 DK

h. WITH [help from another person/(and) special equipment], how much difficulty does -- have getting in and out of bed or chairs -- some, a lot, or is -- completely unable to do this? 22

- 0 No difficulty 2 A lot 9 DK
1 Some 3 Completely unable

Ask 7i and j only if "Help/remind" and/or "Special equip." for **Toilet**; otherwise, skip to 7k. 23

7i. If -- did not [get help from another person/(and) use special equipment], how much difficulty would -- have using the toilet, including getting to the toilet -- some, a lot, or would -- be completely unable to do this?

- 1 Some 3 Completely unable
2 A lot 9 DK

j. WITH [help from another person/(and) special equipment] how much difficulty does -- have using the toilet, including getting to the toilet -- some, a lot, or would -- be completely unable to do this? 24

- 0 No difficulty 2 A lot 9 DK
1 Some 3 Completely unable

Ask 7k and l only if "Help/remind" and/or "Special equip." for **Getting around**; otherwise, skip to 8 on page 42. 25

k. If -- did not [get help from another person/(and) use special equipment], how much difficulty, would -- have getting around inside the home -- some, a lot, or would -- be completely unable to do this?

- 1 Some 3 Completely unable
2 A lot 9 DK

l. WITH [help from another person/(and) special equipment] how much difficulty does -- have getting around inside the home -- some, a lot, or is -- completely unable to do this? 26

- 0 No difficulty 2 A lot 9 DK
1 Some 3 Completely unable

(Go to 8 on page 42)

Notes

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

ADL TABLE 1 - Continued

Ask only if "**Bathing**" marked in X2; otherwise, 8a for next activity. 27-28

8a. How old was -- when -- first had a problem with bathing or showering?

_____ Years old (8d)

96 At birth (8d)
99 DK (8b)

b. Was it before -- was 18 years old? 29

1 Yes (8d)
2 No (8c)
9 DK (8d)

c. Was it before -- was 22 years old? 30

1 Yes
2 No
9 DK

If obvious, mark without asking; otherwise ask: 31

d. Is -- expected to have this problem with bathing or showering for at least 12 months longer?

1 Yes } (8a for next activity)
2 No }
9 DK }

Ask only if "**Dressing**" marked in X2; otherwise, 8a for next activity. 37-38

8a. How old was -- when -- first had a problem with dressing?

_____ Years old (8d)

96 At birth (8d)
99 DK (8b)

b. Was it before -- was 18 years old? 39

1 Yes (8d)
2 No (8c)
9 DK (8d)

c. Was it before -- was 22 years old? 40

1 Yes
2 No
9 DK

If obvious, mark without asking; otherwise ask: 41

d. Is -- expected to have this problem with dressing for at least 12 months longer?

1 Yes } (8a for next activity)
2 No }
9 DK }

Ask only if "**Eating**" marked in X2; otherwise, 8a for next activity. 32-33

8a. How old was -- when -- first had a problem with eating?

_____ Years old (8d)

96 At birth (8d)
99 DK (8b)

b. Was it before -- was 18 years old? 34

1 Yes (8d)
2 No (8c)
9 DK (8d)

c. Was it before -- was 22 years old? 35

1 Yes
2 No
9 DK

If obvious, mark without asking; otherwise ask: 36

d. Is -- expected to have this problem with eating for at least 12 months longer?

1 Yes } (8a for next activity)
2 No }
9 DK }

Ask only if "**Bed or chairs**" marked in X2; otherwise, 8a for next activity. 42-43

8a. How old was -- when -- first had a problem with getting in and out of bed or chairs?

_____ Years old (8d)

96 At birth (8d)
99 DK (8b)

b. Was it before -- was 18 years old? 44

1 Yes (8d)
2 No (8c)
9 DK (8d)

c. Was it before -- was 22 years old? 45

1 Yes
2 No
9 DK

If obvious, mark without asking; otherwise ask: 46

d. Is -- expected to have this problem with getting in and out of bed or chairs for at least 12 months longer?

1 Yes } (8a for next activity)
2 No }
9 DK }

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

ADL TABLE 1 - Continued

| | |
|---|---|
| <p style="font-size: small;">Ask only if "Toilet" marked in X2; otherwise, 8a for next activity. 47-48</p> <p>8a. How old was -- when -- first had a problem with using the toilet?</p> <p>_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d) 99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p>b. Was it before -- was 18 years old? 49</p> <p>1 <input type="checkbox"/> Yes (8d) 2 <input type="checkbox"/> No (8c) 9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p>c. Was it before -- was 22 years old? 50</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> 51</p> <p>d. Is -- expected to have this problem with using the toilet for at least 12 months longer?</p> <p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } (8a for next activity) 9 <input type="checkbox"/> DK }</p> | <p style="font-size: small;">Ask only if "Getting around" marked in X2; otherwise, 9 below. 52-53</p> <p>8a. How old was -- when -- first had a problem with getting around inside the home?</p> <p>_____ Years old (8d)</p> <p>96 <input type="checkbox"/> At birth (8d) 99 <input type="checkbox"/> DK (8b)</p> <hr style="border-top: 1px dashed black;"/> <p>b. Was it before -- was 18 years old? 54</p> <p>1 <input type="checkbox"/> Yes (8d) 2 <input type="checkbox"/> No (8c) 9 <input type="checkbox"/> DK (8d)</p> <hr style="border-top: 1px dashed black;"/> <p>c. Was it before -- was 22 years old? 55</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> 56</p> <p>d. Is -- expected to have this problem with getting around inside the home for at least 12 months longer?</p> <p>1 <input type="checkbox"/> Yes } 2 <input type="checkbox"/> No } (9) 9 <input type="checkbox"/> DK }</p> |
| <p>9. What is the MAIN problem or condition which causes -- trouble in (activities marked in X2)?</p> | <p style="font-size: small;">(Enter condition in X1 and mark box) 57</p> <p>1 <input type="checkbox"/> In C2 } 2 <input type="checkbox"/> Not in C2 } (C2 on page 38 for NP; or 10 on page 56)</p> |

Notes

Section II - DISABILITY - Continued

RT 69
3-4

Part C - ADL / IADL

PERSON 1

Skip to Part D, page 80 if no family members 18+ years old.

HAND CARD DC2.

(Now I will ask about some other activities. These next few questions refer only to (read names of persons 18+).)

10a. Because of a physical, mental, or emotional problem, do (read names of persons 18+) GET HELP OR SUPERVISION FROM ANOTHER PERSON with --

10a.

(1) Preparing their own meals?

1 Yes(10b) 2 No 9 DK 5

(2) Shopping for personal items, such as toilet items or medicine?

1 Yes(10b) 2 No 9 DK 6

(3) Managing money, such as keeping track of expenses or paying bills?

1 Yes(10b) 2 No 9 DK 7

(4) Using the telephone?

1 Yes(10b) 2 No 9 DK 8

(5) Doing heavy work around the house like scrubbing floors, washing windows, and doing heavy yard work?

1 Yes(10b) 2 No 9 DK 9

(6) Doing light work around the house like doing dishes, straightening up, light cleaning, or taking out the trash?

1 Yes(10b) 2 No(C5) 9 DK(C5) 10

b. Who is this?

(Anyone else?)

Mark (X) appropriate box in person's column AND in "Help/supv." column in X3, then continue with 10a, or go to C5.

b.

- 1 Preparing meals 11
- 2 Shopping 12
- 3 Managing money 13
- 4 Using telephone 14
- 5 Heavy housework 15
- 6 Light housework 16

(Mark (X) appropriate box(es) in X3)

ITEM C5

Refer to age and item X3 for each person. Mark (X) first appropriate box.

C5

- 0 Under 18 (NP, or C6 on page 62) 17
- 1 One or more activities marked in X3 (11)
- 2 No activities in X3 (12 on page 60)

Mark (X) box 0 or ask:

11a. Does -- have any difficulty preparing -- own meals?

If doesn't do, ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"*

11a.

- 0 Preparing meals in X3 (11c on page 58) 18
- 1 Yes (Mark X3, then 11b)
- 2 No (11c on page 58)
- 3 Doesn't do/health (Mark X3, then 11c on page 58)
- 9 DK (11c on page 58)

b. How much difficulty does -- have preparing -- own meals -- some, a lot, or is -- unable to do it?

b.

- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK
- (11c on page 58)*

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

PERSON 1

Mark (X) box 0 or ask:

11c. Does -- have any difficulty shopping for personal items?

If doesn't do, ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"*

d. How much difficulty does -- have shopping for personal items -- some, a lot, or is -- unable to do it?

- 11c.**
- 0 Shopping in X3 (11e) 20
 - 1 Yes (Mark X3, then 11d)
 - 2 No (11e)
 - 3 Doesn't do/health (Mark X3, then 11e)
 - 9 DK(11e)

- d.**
- 1 Some 21
 - 2 A lot
 - 3 Unable
 - 9 DK

Mark (X) box 0 or ask:

e. Does -- have any difficulty managing money?

If doesn't do, ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"*

f. How much difficulty does -- have managing money -- some, a lot, or is -- unable to do it?

- e.**
- 0 Managing money in X3 (11g) 22
 - 1 Yes (Mark X3, then 11f)
 - 2 No (11g)
 - 3 Doesn't do/health (Mark X3, then 11g)
 - 9 DK(11g)

- f.**
- 1 Some 23
 - 2 A lot
 - 3 Unable
 - 9 DK

Mark (X) box 0 or ask:

g. Does -- have any difficulty using the telephone?

If doesn't do, ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"*

h. How much difficulty does -- have using the telephone -- some, a lot, or is -- unable to do it?

- g.**
- 0 Telephone in X3 (11i) 24
 - 1 Yes (Mark X3, then 11h)
 - 2 No (11i)
 - 3 Doesn't do/health (Mark X3, then 11i)
 - 9 DK(11i)

- h.**
- 1 Some 25
 - 2 A lot
 - 3 Unable
 - 9 DK

Mark (X) box 0 or ask:

i. Does -- have any difficulty doing heavy work around the house?

If doesn't do, ask: Is this because of a physical, mental, or emotional problem?

*If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"*

j. How much difficulty does -- have doing heavy work around the house -- some, a lot, or is -- unable to do it?

- i.**
- 0 Heavy work in X3 (11k on page 60) 26
 - 1 Yes (Mark X3, then 11j)
 - 2 No (11k on page 60)
 - 3 Doesn't do/health (Mark X3, then 11k on page 60)
 - 9 DK (11k on page 60)

- j.**
- 1 Some
 - 2 A lot
 - 3 Unable
 - 9 DK
- (11k on page 60)*

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

PERSON 1

Mark (X) box 0 or ask:

11k. Does -- have any difficulty doing light work around the house?

If doesn't do, ask: **Is this because of a physical, mental, or emotional problem?**

If "Yes", mark (X) box 3 "Doesn't do/health"
If "No", mark (X) box 2 "No"

i. How much difficulty does -- have doing light work around the house -- some, a lot, or is -- unable to do it?

11k.

- 0 Light work in X3
(C5 on page 56 for NP, or C6 on page 62)
- 1 Yes (Mark X3, then 11i)
- 2 No (C5 on page 56 for NP, or C6 on page 62)
- 3 Doesn't do/health (Mark X3, then C5 on page 56 for NP, or C6 on page 62)
- 9 DK (C5 on page 56 for NP, or C6 on page 62)

28

i.

- 1 Some
 2 A lot
 3 Unable
 9 DK
- (C5 on page 56 for NP, or C6 on page 62)

29

Hand Card DC2.

12a. Because of a physical, mental, or emotional problem does -- have any difficulty with any of [these/the following] activities? Read categories if telephone interview.

If "Yes", ask "Which"? and mark the appropriate box(es), in person's column AND in "Difficulty/doesn't do" column in X3.

If doesn't do, ask: **Is this because of a physical, mental, or emotional problem?**

If "Yes", mark the box for that activity
If "No", do not make any entries

Mark (X) box 0 only if no other box(es) are marked.

Ask only if box 1 "Preparing meals" in 12a; otherwise, skip to 12c.

b. How much difficulty does -- have preparing -- own meals -- some, a lot, or is -- unable to do it?

Ask only if box 2 "Shopping" in 12a; otherwise, skip to 12d.

c. How much difficulty does -- have shopping for personal items -- some, a lot, or is -- unable to do it?

Ask only if box 3 "Managing money" in 12a; otherwise, skip to 12e.

d. How much difficulty does -- have managing money -- some, a lot, or is -- unable to do it?

Ask only if box 4 "Using the telephone" in 12a; otherwise, skip to 12f on page 62.

e. How much difficulty does -- have using the telephone -- some, a lot, or is -- unable to do it?

12a.

- 0 No difficulty (C5 for NP, or C6)
- 1 Preparing meals
- 2 Shopping
- 3 Managing money
- 4 Using the telephone
- 5 Heavy housework
- 6 Light housework
- (Mark (X) appropriate box(es) in X3)

30

31

32

33

34

35

36

b.

- 1 Some
 2 A lot
 3 Unable
 9 DK

37

c.

- 1 Some
 2 A lot
 3 Unable
 9 DK

38

d.

- 1 Some
 2 A lot
 3 Unable
 9 DK

39

e.

- 1 Some
 2 A lot
 3 Unable
 9 DK
- (12f on page 62)

40

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

PERSON 1

Ask only if box 5 "Heavy housework" in 12a; otherwise, skip to 12g.

12f. How much difficulty does -- have doing heavy work around the house -- some, a lot, or is -- unable to do it?

- 12f.** 1 Some
 2 A lot
 3 Unable
 9 DK

41

Ask only if box 6 "Light housework" in 12a; otherwise, go to C5 on page 56 for NP, or C6.

g. How much difficulty does -- have doing light work around the house -- some, a lot, or is -- unable to do it?

- g.** 1 Some
 2 A lot
 3 Unable
 9 DK
- } (C5 on page 56 for NP, or C6)

42

**ITEM
C6**

Refer to age and item X3. Mark (X) first appropriate box.

- C6** 0 Under 18 (NP, or Part D on page 80)
 1 One or more activities marked in X3 (IADL table)
 2 No activities in X3 (NP, or Part D on page 80)

43

If no more persons in family, skip to Part D on page 80.

Notes

Section II - DISABILITY - Continued

RT 70

Part C - ADL / IADL - Continued

IADL TABLE 1

| | | | | | | | | | | | | | | | | | |
|--|---|---|--|--|-------------------------------|---|---|--|--|---|---|----|--|----|---|----|----|
| ITEM C7 | Enter person's number and name. | C7 | Person number _____ Name _____ | 3-4 | | | | | | | | | | | | | |
| ITEM C8 | Refer to X3 for this person. Mark (X) first appropriate box. | C8 | 1 <input type="checkbox"/> "Help/supv." (13) 2 <input type="checkbox"/> "Difficulty/doesn't do" (15 on page 66) | 5 | | | | | | | | | | | | | |
| 13a. You said that -- gets help or supervision with (activities with "help/supv." in X3). Who gives this help? Anyone else? Mark (X) all that apply. <hr/> If ONLY help is from spouse/child(ren)/parent, mark (X) box 0; otherwise, ask: b. Is any of this help paid for? c. Which helpers are paid? Anyone else? Mark (X) all the apply. | | 13a. Household members <table style="display: inline-table; border: none; margin-right: 20px;"> <tr><td>1 <input type="checkbox"/> Relative(s)</td><td style="border: 1px solid black; padding: 2px;">6</td></tr> <tr><td>2 <input type="checkbox"/> Nonrelative(s)</td><td style="border: 1px solid black; padding: 2px;">7</td></tr> </table> <table style="display: inline-table; border: none;"> <tr><td>3 <input type="checkbox"/> Relative(s)</td><td style="border: 1px solid black; padding: 2px;">8</td></tr> <tr><td>4 <input type="checkbox"/> Nonrelative(s)</td><td style="border: 1px solid black; padding: 2px;">9</td></tr> </table> | | 1 <input type="checkbox"/> Relative(s) | 6 | 2 <input type="checkbox"/> Nonrelative(s) | 7 | 3 <input type="checkbox"/> Relative(s) | 8 | 4 <input type="checkbox"/> Nonrelative(s) | 9 | 10 | | | | | |
| | | 1 <input type="checkbox"/> Relative(s) | 6 | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> Nonrelative(s) | 7 | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Relative(s) | 8 | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> Nonrelative(s) | 9 | | | | | | | | | | | | | | | | |
| b. <table style="display: inline-table; border: none; margin-right: 20px;"> <tr><td>1 <input type="checkbox"/> Yes (13c)</td><td rowspan="3" style="font-size: 2em; vertical-align: middle;">}</td><td rowspan="3" style="vertical-align: middle;">(14)</td></tr> <tr><td>2 <input type="checkbox"/> No</td></tr> <tr><td>9 <input type="checkbox"/> DK</td></tr> </table> | | 1 <input type="checkbox"/> Yes (13c) | } | (14) | 2 <input type="checkbox"/> No | 9 <input type="checkbox"/> DK | c. Household members <table style="display: inline-table; border: none; margin-right: 20px;"> <tr><td>1 <input type="checkbox"/> Relative(s)</td><td style="border: 1px solid black; padding: 2px;">11</td></tr> <tr><td>2 <input type="checkbox"/> Nonrelative(s)</td><td style="border: 1px solid black; padding: 2px;">12</td></tr> </table> <table style="display: inline-table; border: none;"> <tr><td>3 <input type="checkbox"/> Relative(s)</td><td style="border: 1px solid black; padding: 2px;">13</td></tr> <tr><td>4 <input type="checkbox"/> Nonrelative(s)</td><td style="border: 1px solid black; padding: 2px;">14</td></tr> </table> | | 1 <input type="checkbox"/> Relative(s) | 11 | 2 <input type="checkbox"/> Nonrelative(s) | 12 | 3 <input type="checkbox"/> Relative(s) | 13 | 4 <input type="checkbox"/> Nonrelative(s) | 14 | 17 |
| 1 <input type="checkbox"/> Yes (13c) | } | (14) | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 9 <input type="checkbox"/> DK | | | | | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> Relative(s) | 11 | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> Nonrelative(s) | 12 | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Relative(s) | 13 | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> Nonrelative(s) | 14 | | | | | | | | | | | | | | | | |
| Ask 14a and b only if "Help/supv." for Preparing meals ; otherwise, skip to 14c. | | Ask 14c and d only if "Help or supv." for Shopping ; otherwise, skip to 14e. | | 15 | | | | | | | | | | | | | |
| 14a. If -- did not get help or supervision from another person, how much difficulty would -- have preparing -- meals on -- own -- some, a lot, or would -- be completely unable to do this? 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK | | 14c. If -- did not get help or supervision from another person, how much difficulty would -- have shopping for personal items on -- own -- some, a lot, or would -- be completely unable to do this? 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK | | 16 | | | | | | | | | | | | | |
| b. WITH help or supervision, how much difficulty does -- have preparing -- meals -- some, a lot, or is -- completely unable to do this? 0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable | | d. WITH help or supervision, how much difficulty does -- have shopping for personal items -- some, a lot, or is -- completely unable to do this? 0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable | | 18 | | | | | | | | | | | | | |

Notes

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

IADL TABLE 1 - Continued

| | |
|--|---|
| <p><i>Ask 14e and f only if "Help/supv." for Managing money; otherwise, skip to 14g.</i> 19</p> <p>14e. If -- did not get help or supervision from another person, how much difficulty would -- managing money on -- own -- some, a lot, or is -- be completely unable to do this?</p> <p>1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p>f. WITH help or supervision, how much difficulty does -- have managing money -- some, a lot, or is -- completely unable to do this? 20</p> <p>0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable</p> | <p><i>Ask 14i and j only if "Help/supv." for Heavy housework; otherwise, skip to 14k.</i> 23</p> <p>14i. If -- did not get help or supervision from another person, how much difficulty would -- have doing heavy work around the house -- some, a lot, or would -- be completely unable to do this?</p> <p>1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p>j. WITH help or supervision, how much difficulty does -- have doing heavy work around the house -- some, a lot, or is -- completely unable to do this? 24</p> <p>0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable</p> |
| <p><i>Ask 14g and h only if "Help/supv. for Telephone"; otherwise, skip to 14i.</i> 21</p> <p>g. If -- did not get help or supervision from another person, how much difficulty would -- have using the telephone -- some, a lot, or would -- be completely unable to do this?</p> <p>1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p>h. WITH help or supervision, how much difficulty does -- have using the telephone -- some, a lot, or is -- completely unable to do this? 22</p> <p>0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable</p> | <p><i>Ask 14k and l only if "Help/supv." for Light housework; otherwise, skip to 15 on page 66.</i> 25</p> <p>k. If -- did not get help or supervision from another person, how much difficulty would -- have doing light work around the house -- some, a lot, or would -- be completely unable to do this?</p> <p>1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p>l. WITH help or supervision, how much difficulty does -- have doing light work around the house -- some, a lot, or is -- completely unable to do this? 26</p> <p>0 <input type="checkbox"/> No difficulty 2 <input type="checkbox"/> A lot 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Some 3 <input type="checkbox"/> Completely unable</p> <p align="center"><i>(Go to 15 on page 66)</i></p> |

Notes

Section II - DISABILITY - Continued

Part C - ADL / IADL - Continued

IADL TABLE 1 - Continued

| | |
|--|---|
| <p><i>Ask only if "Preparing meals" marked in X3; otherwise, 15a for next activity.</i> 27-28</p> <p>15a. How old was -- when -- first had a problem with preparing -- own meals?</p> <p>_____ Years old (15d) <input type="checkbox"/> At birth (15d) <input type="checkbox"/> DK (15b)</p> <hr/> <p>b. Was it before -- was 18 years old? 29</p> <p>1 <input type="checkbox"/> Yes (15d) 2 <input type="checkbox"/> No (15c) 9 <input type="checkbox"/> DK (15d)</p> <hr/> <p>c. Was it before -- was 22 years old? 30</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr/> <p><i>If obvious, mark without asking; otherwise ask:</i> 31</p> <p>d. Is -- expected to have this problem with preparing -- own meals for at least 12 months longer?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (15a for next activity)</p> | <p><i>Ask only if "Shopping" marked in X3; otherwise, 15a for next activity.</i> 37-38</p> <p>15a. How old was -- when -- first had a problem with shopping for personal items?</p> <p>_____ Years old (15d) <input type="checkbox"/> At birth (15d) <input type="checkbox"/> DK (15b)</p> <hr/> <p>b. Was it before -- was 18 years old? 39</p> <p>1 <input type="checkbox"/> Yes (15d) 2 <input type="checkbox"/> No (15c) 9 <input type="checkbox"/> DK (15d)</p> <hr/> <p>c. Was it before -- was 22 years old? 40</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr/> <p><i>If obvious, mark without asking; otherwise ask:</i> 41</p> <p>d. Is -- expected to have this problem with shopping for personal items for at least 12 months longer?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (15a for next activity)</p> |
| <p><i>Ask only if "Managing money" marked in X3; otherwise, 15a for next activity.</i> 32-33</p> <p>15a. How old was -- when -- first had a problem with managing money?</p> <p>_____ Years old (15d) <input type="checkbox"/> At birth (15d) <input type="checkbox"/> DK (15b)</p> <hr/> <p>b. Was it before -- was 18 years old? 34</p> <p>1 <input type="checkbox"/> Yes (15d) 2 <input type="checkbox"/> No (15c) 9 <input type="checkbox"/> DK (15d)</p> <hr/> <p>c. Was it before -- was 22 years old? 35</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr/> <p><i>If obvious, mark without asking; otherwise ask:</i> 36</p> <p>d. Is -- expected to have this problem managing money for at least 12 months longer?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (15a for next activity)</p> | <p><i>Ask only if "Telephone" marked in X3; otherwise, 15a, for next activity.</i> 42-43</p> <p>15a. How old was -- when -- first had a problem with using the telephone?</p> <p>_____ Years old (15d) <input type="checkbox"/> At birth (15d) <input type="checkbox"/> DK (15b)</p> <hr/> <p>b. Was it before -- was 18 years old? 44</p> <p>1 <input type="checkbox"/> Yes (15d) 2 <input type="checkbox"/> No (15c) 9 <input type="checkbox"/> DK (15d)</p> <hr/> <p>c. Was it before -- was 22 years old? 45</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr/> <p><i>If obvious, mark without asking; otherwise ask:</i> 46</p> <p>d. Is -- expected to have this problem using the telephone for at least 12 months longer?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (15a for next activity)</p> |

Section II – DISABILITY – Continued

Part C – ADL / IADL – Continued

IADL TABLE 1 – Continued

| | |
|--|---|
| <p><i>Ask only if "Heavy work" marked in X3; otherwise, 15a for next activity.</i> 47-48</p> <p>15a. How old was -- when -- first had a problem with doing heavy work around the house?</p> <p>_____ Years old (15d)</p> <p><input type="checkbox"/> At birth (15d) <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p>b. Was it before -- was 18 years old? 49</p> <p><input type="checkbox"/> Yes (15d) <input type="checkbox"/> No (15c) <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p>c. Was it before -- was 22 years old? 50</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> 51</p> <p>d. Is -- expected to have this problem doing heavy work around the house for at least 12 months longer?</p> <p><input type="checkbox"/> Yes } <input type="checkbox"/> No } (15a for next activity) <input type="checkbox"/> DK }</p> | <p><i>Ask only if "Light work" marked in X3; otherwise, 16, below.</i> 52-53</p> <p>15a. How old was -- when -- first had a problem with doing light work around the house?</p> <p>_____ Years old (15d)</p> <p><input type="checkbox"/> At birth (15d) <input type="checkbox"/> DK (15b)</p> <hr style="border-top: 1px dashed black;"/> <p>b. Was it before -- was 18 years old? 54</p> <p><input type="checkbox"/> Yes (15d) <input type="checkbox"/> No (15c) <input type="checkbox"/> DK (15d)</p> <hr style="border-top: 1px dashed black;"/> <p>c. Was it before -- was 22 years old? 55</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p><i>If obvious, mark without asking; otherwise ask:</i> 56</p> <p>d. Is -- expected to have this problem doing light work around the house for at least 12 months longer?</p> <p><input type="checkbox"/> Yes } <input type="checkbox"/> No } (16) <input type="checkbox"/> DK }</p> |
| <p>16. What is the MAIN problem or condition which causes -- trouble in (activities marked in X3)?</p> | <p><i>(Enter condition in X1 and mark box)</i></p> <p><input type="checkbox"/> In C2 } <input type="checkbox"/> Not in C2 } (C6 on page 62 for NP, or part D on page 80)</p> |

Notes

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION

RT 71

3-4

PERSON 1

5

**ITEM
D1**

Refer to ages of all family members.

D1

- 1 All under 18 (Section G on page 112)
2 Any 18+ (1)

These next few questions also refer to family members who are 18 years old or older, that is (read names of nondeleted persons 18+).

6

1a. Do (names of persons 18+) have ANY difficulty lifting something as heavy as 10 pounds, such as a full bag of groceries?

1a.

- 1 Yes (1b)
2 No
9 DK } (2 on page 82)

b. Who is this?

b.

Mark (X) "Difficulty lifting" box in person's column.

- 1 Difficulty lifting

c. Anyone else?

- Yes (Reask 1b and c) No

Ask 1d-g for each person with "Difficulty lifting" marked in 1b.

8

d. How much difficulty does -- have lifting 10 pounds, some, a lot, or is -- completely unable to do this?

d.

- 1 Some difficulty
2 A lot of difficulty
3 Completely unable
9 DK

e. At what age did -- first have difficulty doing this?

e.

- ____ Years old 9-10
OR
96 Always had difficulty
97 Never able
99 DK

Ask only if "Completely unable" in 1d; otherwise, skip to 1g.

11

f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?

f.

- 1 Yes
2 No
9 DK

g. Did this difficulty result from a motor vehicle accident?

g.

- 1 Yes
2 No
9 DK } (1d for NP in 1b, or 2 on page 82)

12

Notes

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

PERSON 1

2a. Do (names of persons 18+) have any difficulty walking up 10 steps without resting?

2a. 13
 1 Yes (2b)
 2 No } (3 on page 84)
 9 DK }

b. Who is this?

Mark (X) "Difficulty walking up steps" box in person's column.

b. 14
 1 Difficulty walking up steps

c. Anyone else?

Yes (Reask 2b and c) No

Ask 2d-g for each person with "Difficulty walking up steps" marked in 2b.

d. 15

d. How much difficulty does -- have walking up 10 steps without rest, some, a lot, or is -- completely unable to do this?

1 Some difficulty
 2 A lot of difficulty
 3 Completely unable
 9 DK

e. At what age did -- first have difficulty doing this?

_____ Years old 16-17

OR

96 Always had difficulty
 97 Never able
 99 DK

Ask only if "Completely unable" in 2d; otherwise, skip to 2g.

f. 18

f. [Do you expect/Is -- expected] to remain unable to do this for at least 12 months longer?

1 Yes
 2 No
 9 DK

g. Did this difficulty result from a motor vehicle accident?

g. 19

1 Yes } (2d for NP in 2b,
 2 No } or 3 on page 84)
 9 DK }

Notes

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

| | | PERSON 1 | |
|--|---|--|--|
| <p>3a. Do (names of persons 18+) have any difficulty walking a quarter of a mile - about 3 city blocks?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Difficulty walking" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (<i>Reask 3b and c</i>) <input type="checkbox"/> No</p> <p>-----</p> <p><i>Ask 3d-g for each person with "Difficulty walking" marked in 3b.</i></p> <p>d. How much difficulty does -- have walking a quarter of a mile, some, a lot, or is -- completely unable to do this?</p> <p>-----</p> <p>e. At what age did -- first have difficulty doing this?</p> <p>-----</p> <p><i>Ask only if "Completely unable" in 3d; otherwise, skip to 3g.</i></p> <p>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</p> <p>-----</p> <p>g. Did this difficulty result from a motor vehicle accident?</p> | <p>3a.</p> <p>1 <input type="checkbox"/> Yes (<i>3b</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>4 on page 86</i>)</p> <p>b.</p> <p>1 <input type="checkbox"/> Difficulty walking</p> <p>d.</p> <p>1 <input type="checkbox"/> Some difficulty 2 <input type="checkbox"/> A lot of difficulty 3 <input type="checkbox"/> Completely unable 9 <input type="checkbox"/> DK</p> <p>e.</p> <p>_____ Years old OR 96 <input type="checkbox"/> Always had difficulty 97 <input type="checkbox"/> Never able 99 <input type="checkbox"/> DK</p> <p>f.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>g.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>3d for NP in 3b, or 4 on page 86</i>)</p> | <p>20</p> <p>21</p> <p>22</p> <p>23-24</p> <p>25</p> <p>26</p> | |
| <p>Notes</p> | | | |

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

PERSON 1

| | |
|--|--|
| <p>4a. Do (names of persons 18+) have any difficulty standing for about 20 minutes?</p> | <p>4a. 27 <input type="checkbox"/> Yes (4b) <input type="checkbox"/> No } (5 on page 88) <input type="checkbox"/> DK }</p> |
| <p>b. Who is this? Mark (X) "Difficulty standing" box in person's column.</p> | <p>b. 28 <input type="checkbox"/> Difficulty standing</p> |
| <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No Ask 4d-g for each person with "Difficulty standing" marked in 4b.</p> | <p>d. 29 <input type="checkbox"/> Some difficulty <input type="checkbox"/> A lot of difficulty <input type="checkbox"/> Completely unable <input type="checkbox"/> DK</p> |
| <p>e. At what age did -- first have difficulty doing this?</p> | <p>e. 30-31 _____ Years old OR <input type="checkbox"/> Always had difficulty <input type="checkbox"/> Never able <input type="checkbox"/> DK</p> |
| <p>f. [Do you expect/ls -- expected] to remain unable to do this for at least 12 months longer?</p> | <p>f. 32 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> |
| <p>g. Did this difficulty result from a motor vehicle accident?</p> | <p>g. 33 <input type="checkbox"/> Yes } (4d for NP in 4b, <input type="checkbox"/> No } or 5 on page 88) <input type="checkbox"/> DK }</p> |

Notes

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

PERSON 1

6a. Do (names of persons 18+) have any difficulty reaching up over the head or reaching out as if to shake someone's hand?

6a. 41
 1 Yes (6b)
 2 No
 9 DK } (7 on page 92)

b. Who is this?

Mark (X) "Difficulty reaching" box in person's column.

b. 42
 1 Difficulty reaching

c. Anyone else?

Yes (Reask 6b and c) No

Ask 6d-g for each person with "Difficulty reaching" marked in 6b.

d. 43
 1 Some difficulty
 2 A lot of difficulty
 3 Completely unable
 9 DK

e. At what age did -- first have difficulty doing this?

_____ Years old 44-45
 OR
 96 Always had difficulty
 97 Never able
 99 DK

Ask only if "Completely unable" in 6d; otherwise, skip to 6g.

f. [Do you expect/Is -- expected] to remain unable to do this for at least 12 months longer?

f. 46
 1 Yes
 2 No
 9 DK

g. Did this difficulty result from a motor vehicle accident?

g. 47
 1 Yes
 2 No
 9 DK } (6d for NP in 6b, or 7 on page 92)

Notes

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

PERSON 1

7a. Do (names of persons 18+) have any difficulty using fingers to grasp or handle something such as picking up a glass from a table?

- 7a.** 48
 1 Yes (7b)
 2 No } (8 on page 94)
 9 DK

b. Who is this?

Mark (X) "Difficulty using fingers" box in person's column.

- b.** 49
 1 Difficulty using fingers

c. Anyone else?

- Yes (Reask 7b and c) No

Ask 7d-g for each person with "Difficulty using fingers" marked in 7b.

- d.** 50
 1 Some difficulty
 2 A lot of difficulty
 3 Completely unable
 9 DK

e. At what age did -- first have difficulty doing this?

- 51-52
 _____ Years old
 OR
 96 Always had difficulty
 97 Never able
 99 DK

Ask only if "Completely unable" in 7d; otherwise, skip to 7g.

f. [Do you expect/Is -- expected] to remain unable to do this for at least 12 months longer?

- f.** 53
 1 Yes
 2 No
 9 DK

g. Did this difficulty result from a motor vehicle accident?

- g.** 54
 1 Yes } (7d for NP in 7b,
 2 No } or 8 on page 94)
 9 DK

Notes

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

PERSON 1

| | |
|--|--|
| <p>8a. Do (names of persons 18+) have any difficulty holding a pen or pencil?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Difficulty holding a pen or pencil" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (<i>Reask 8b and c</i>) <input type="checkbox"/> No</p> <p>-----</p> <p><i>Ask 8d-g for each person with "Difficulty holding a pen or pencil" marked in 8b.</i></p> <p>d. How much difficulty -- have holding a pen or pencil, some, a lot, or is -- completely unable to do this?</p> <p>-----</p> <p>e. At what age did -- first have difficulty doing this?</p> <p>-----</p> <p><i>Ask only if "Completely unable" in 8d; otherwise, skip to 8g.</i></p> <p>f. Is -- expected to remain unable to do this for at least 12 months longer?</p> <p>-----</p> <p>g. Did this difficulty result from a motor vehicle accident?</p> | <p>8a. 55</p> <p>1 <input type="checkbox"/> Yes (<i>8b</i>) 2 <input type="checkbox"/> No } (<i>D2</i>) 9 <input type="checkbox"/> DK }</p> <hr/> <p>b. 56</p> <p>1 <input type="checkbox"/> Difficulty holding a pen or pencil</p> <hr/> <p>d. 57</p> <p>1 <input type="checkbox"/> Some difficulty 2 <input type="checkbox"/> A lot of difficulty 3 <input type="checkbox"/> Completely unable 9 <input type="checkbox"/> DK</p> <hr/> <p>e. 58-59</p> <p>____ Years old OR 96 <input type="checkbox"/> Always had difficulty 97 <input type="checkbox"/> Never able 99 <input type="checkbox"/> DK</p> <hr/> <p>f. 60</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr/> <p>g. 61</p> <p>1 <input type="checkbox"/> Yes } (<i>8d for NP in 8b, or D2</i>) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }</p> <hr/> <p>ITEM D2 62</p> <p><i>Refer to questions 1b, 2b, 3b, 4b, 5b, 6b, 7b, and 8b on pages 80-95 in the HIS-2.</i></p> <p>D2 1 <input type="checkbox"/> Any limitations marked (<i>9</i>) 2 <input type="checkbox"/> No limitations marked (<i>NP</i>)</p> <hr/> <p>9. 63</p> <p><i>(Enter condition in X1 and mark box)</i></p> <p>1 <input type="checkbox"/> In C2 } (<i>D2 for NP, or D3 on page 96</i>) 2 <input type="checkbox"/> Not in C2 }</p> |
|--|--|

Section II - DISABILITY - Continued

Part D - FUNCTIONAL LIMITATION - Continued

PERSON 1

64

**ITEM
D3**

Refer to age or HIS-1, Part B, Questions 2a/b and 5a/b (pages 4-5).

D3

- 2 Under 18 (NP, or Part E on page 98)
- 1 Yes in 2a/b or 5a/b (10)
- 2 Other (NP, or Part E on page 98)

10. Earlier, I was told that -- was unable to work or was limited in the kind or amount of work -- could do because of an impairment or health problem. About how long has -- been unable to work or limited in the kind or amount of work -- can do?

If less than one month, enter 1 month.

10.

65-67

- Number { 1 Months
 2 Years
OR
3 Never able
- (D3 for NP, or Part E on page 98)*

Notes

Section II - DISABILITY - Continued

RT 72

Part E - MENTAL HEALTH

PERSON 1

3-4

These next questions are about mental and emotional health. They refer again only to (names of nondeleted persons age 18+).

| | |
|---|---|
| <p>1a. Are (read names of persons 18+) FREQUENTLY depressed or anxious?</p> <p>-----</p> <p>b. Who is this? Mark (X) "Depressed or anxious" box in person's column.</p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No (2)</p> | <p>1a. 5</p> <p>1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No } (2) 9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 6</p> <p>1 <input type="checkbox"/> Depressed or anxious</p> |
| <p>2a. Do (any of/either of) you have a lot of trouble making or keeping friendships?</p> <p>-----</p> <p>b. Who is this? Mark (X) "Trouble with friendships" box in person's column.</p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 2b and c) <input type="checkbox"/> No (3)</p> | <p>2a. 7</p> <p>1 <input type="checkbox"/> Yes (2b) 2 <input type="checkbox"/> No } (3) 9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 8</p> <p>1 <input type="checkbox"/> Trouble with friendships</p> |
| <p>3a. Do (any of/either of) you have a lot of trouble getting along with other people in social or recreational settings?</p> <p>-----</p> <p>b. Who is this? Mark (X) "Trouble in social settings" box in person's column.</p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 3b and c) <input type="checkbox"/> No (4)</p> | <p>3a. 9</p> <p>1 <input type="checkbox"/> Yes (3b) 2 <input type="checkbox"/> No } (4) 9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 10</p> <p>1 <input type="checkbox"/> Trouble in social settings</p> |
| <p>4a. Do (any of/either of) you have a lot of trouble concentrating long enough to complete everyday tasks?</p> <p>-----</p> <p>b. Who is this? Mark (X) "Trouble concentrating" box in person's column.</p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No (5 on page 100)</p> | <p>4a. 11</p> <p>1 <input type="checkbox"/> Yes (4b) 2 <input type="checkbox"/> No } (5 on page 98) 9 <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 12</p> <p>1 <input type="checkbox"/> Trouble concentrating</p> |

Section II - DISABILITY - Continued

Part E - MENTAL HEALTH - Continued

PERSON 1

| | |
|--|--|
| <p>5a. Do (any of/either of) you have SERIOUS difficulty coping with day-to-day stresses?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Trouble coping with stress" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No (6)</p> | <p>5a. 13</p> <p>1 <input type="checkbox"/> Yes (5b) 2 <input type="checkbox"/> No } (6) 9 <input type="checkbox"/> DK }</p> <p>b. 14</p> <p>1 <input type="checkbox"/> Trouble coping with stress</p> |
| <p>6a. Are (any of/either of) you FREQUENTLY confused, disoriented or forgetful?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Confused" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No (7)</p> | <p>6a. 15</p> <p>1 <input type="checkbox"/> Yes (6b) 2 <input type="checkbox"/> No } (7) 9 <input type="checkbox"/> DK }</p> <p>b. 16</p> <p>1 <input type="checkbox"/> Confused</p> |
| <p>7a. Do (any of/either of) you have phobias or UNREASONABLY strong fears, that is, a fear of something or some situation where most people would not be afraid?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Phobia" box in person's column.</i></p> <p>-----</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 7b and c) <input type="checkbox"/> No (Check Item E1)</p> | <p>7a. 17</p> <p>1 <input type="checkbox"/> Yes (7b) 2 <input type="checkbox"/> No } (Check Item E1) 9 <input type="checkbox"/> DK }</p> <p>b. 18</p> <p>1 <input type="checkbox"/> Phobia</p> |
| <p>ITEM E1</p> <p><i>Refer to age or questions 1b, 2b, 3b, 4b, 5b, 6b, and 7b for each person.</i></p> | <p>E1 19</p> <p>2 <input type="checkbox"/> Under 18 (NP, or 9 on page 102) 1 <input type="checkbox"/> Any box marked (8) 2 <input type="checkbox"/> No box marked (NP, or 9 on page 102)</p> |
| <p>8. During the past 12 months, did any of these problems SERIOUSLY interfere with -- ability to work or attend school or to manage -- day-to-day activities?</p> | <p>8. 20</p> <p>1 <input type="checkbox"/> Yes } (E1 for NP, or 9 on page 102) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }</p> |

Section II - DISABILITY - Continued

Part E - MENTAL HEALTH - Continued

PERSON 1

These next questions are about specific mental and emotional disorders. Again, I will only ask about *(names of persons 18 years of age and older)*.

| | | | | | | | | | | | | | | | | | |
|---|---|--|-----------------------------|--|-----------------------------|---|-----------------------------|---|-----------------------------|---|-----------------------------|-------------------------------------|-----------------------------|--|-----------------------------|--|-----------------------------|
| <p>9a. During the past 12 months, did <i>(names of persons 18+)</i> have -</p> <p>(1) Schizophrenia (skit-suh-freee'-nee-uh)?</p> <p>(2) Paranoid or delusional disorder, other than schizophrenia?</p> <p>(3) Manic episodes or manic depression, also called bipolar disorder?</p> <p>(4) Major depression? Major depression is a depressed mood and loss of interest in almost all activities FOR AT LEAST 2 WEEKS.</p> <p>(5) Anti-social personality, obsessive-compulsive personality, or any other SEVERE personality disorder?</p> <p>(6) Alzheimer's (alltz'hi-marz) disease or another type of senile disorder?</p> <p>(7) Alcohol abuse disorder?</p> <p>(8) Drug abuse disorder?</p> <p>b. Who is this? <i>Mark (X) appropriate box in person's column and enter condition in X1.</i></p> <p>c. Anyone else? If "Yes" (Reask 9b and c) If "No" (9a for next disorder, or 10 on page 104)</p> | <p>9a. <input type="checkbox"/> 21</p> <p>(1) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 21</p> <p>(2) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 22</p> <p>(3) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 23</p> <p>(4) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 24</p> <p>(5) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 25</p> <p>(6) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 26</p> <p>(7) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK <input type="checkbox"/> 27</p> <p>(8) 1 <input type="checkbox"/> Yes (9b) 2 <input type="checkbox"/> No (10) 9 <input type="checkbox"/> DK (10) <input type="checkbox"/> 28</p> <p>b.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>1 <input type="checkbox"/> Schizophrenia</td><td align="right"><input type="checkbox"/> 29</td></tr> <tr><td>2 <input type="checkbox"/> Paranoid disorder</td><td align="right"><input type="checkbox"/> 30</td></tr> <tr><td>3 <input type="checkbox"/> Bipolar disorder</td><td align="right"><input type="checkbox"/> 31</td></tr> <tr><td>4 <input type="checkbox"/> Major depression</td><td align="right"><input type="checkbox"/> 32</td></tr> <tr><td>5 <input type="checkbox"/> Personality disorder</td><td align="right"><input type="checkbox"/> 33</td></tr> <tr><td>6 <input type="checkbox"/> Senility</td><td align="right"><input type="checkbox"/> 34</td></tr> <tr><td>7 <input type="checkbox"/> Alcohol abuse</td><td align="right"><input type="checkbox"/> 35</td></tr> <tr><td>8 <input type="checkbox"/> Drug abuse disorder</td><td align="right"><input type="checkbox"/> 36</td></tr> </table> | 1 <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> 29 | 2 <input type="checkbox"/> Paranoid disorder | <input type="checkbox"/> 30 | 3 <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> 31 | 4 <input type="checkbox"/> Major depression | <input type="checkbox"/> 32 | 5 <input type="checkbox"/> Personality disorder | <input type="checkbox"/> 33 | 6 <input type="checkbox"/> Senility | <input type="checkbox"/> 34 | 7 <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> 35 | 8 <input type="checkbox"/> Drug abuse disorder | <input type="checkbox"/> 36 |
| 1 <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> 29 | | | | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> Paranoid disorder | <input type="checkbox"/> 30 | | | | | | | | | | | | | | | | |
| 3 <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> 31 | | | | | | | | | | | | | | | | |
| 4 <input type="checkbox"/> Major depression | <input type="checkbox"/> 32 | | | | | | | | | | | | | | | | |
| 5 <input type="checkbox"/> Personality disorder | <input type="checkbox"/> 33 | | | | | | | | | | | | | | | | |
| 6 <input type="checkbox"/> Senility | <input type="checkbox"/> 34 | | | | | | | | | | | | | | | | |
| 7 <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> 35 | | | | | | | | | | | | | | | | |
| 8 <input type="checkbox"/> Drug abuse disorder | <input type="checkbox"/> 36 | | | | | | | | | | | | | | | | |

Notes

| Section II – DISABILITY – Continued | | | |
|--|---|---|-------------------------------|
| Part E – MENTAL HEALTH – Continued | | PERSON 1 | |
| <p>10a. DURING THE PAST 12 MONTHS, did (any of/either of) you have any OTHER mental or emotional disorders? Include only those disorders which SERIOUSLY interfered with [their/your] ability to work or attend school or to manage [their/your] day-to-day activities.</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Other disorder" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 10b and c) <input type="checkbox"/> No</p> <p>-----</p> <p><i>Ask for each person with "Other disorder" marked in 10b.</i></p> <p>d. What would you call the disorder -- has? <i>If more than one other disorder, probe for the "Main" one causing difficulty.</i></p> | | <p>10a. <input type="checkbox"/> Yes (10b) <input type="checkbox"/> No } (11) <input type="checkbox"/> DK } (11)</p> <p>b. <input type="checkbox"/> Other disorder</p> <p>-----</p> <p>d. (Enter condition in X1 and mark box) <input type="checkbox"/> In C2 } (10d for NP with <input type="checkbox"/> Not in C2 } 10b, or 11)</p> | <p>37</p> <p>38</p> <p>39</p> |
| <p>11a. DURING THE PAST 12 MONTHS, did (any of/either of) you take any prescription medication for any ongoing mental or emotional condition?</p> <p>-----</p> <p>b. Who is this? <i>Mark (X) "Medication" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 11b and c) <input type="checkbox"/> No (Item E2)</p> | | <p>11a. <input type="checkbox"/> Yes (11b) <input type="checkbox"/> No } (Item E2) <input type="checkbox"/> DK }</p> <p>b. <input type="checkbox"/> Medication</p> | <p>40</p> <p>41</p> |
| <p>ITEM E2</p> | <p><i>Refer to age or questions 1b, 2b, 3b, 4b, 5b, 6b, 7b, 9b, 10b, and 11b for each person.</i></p> | <p>E2 <input type="checkbox"/> Under 18 (NP, or Part F on page 106) <input type="checkbox"/> Any box marked (12) <input type="checkbox"/> No box marked (NP, or Part F on page 106)</p> | <p>42</p> |
| <p>12a. Because of [this/any of these] mental or emotional problem(s), is -- UNABLE TO WORK OR LIMITED IN THE KIND OR AMOUNT OF WORK -- CAN DO?</p> <p>-----</p> <p>b. Because of [this/any of these] mental or emotional problem(s), does -- have trouble FINDING OR KEEPING A JOB OR DOING JOB TASKS?</p> | | <p>12a. <input type="checkbox"/> Yes (13) <input type="checkbox"/> No } (12b) <input type="checkbox"/> DK }</p> <p>b. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> | <p>43</p> <p>44</p> |
| <p>13. Because of [this/any of these] mental or emotional problem(s), during the past 12 months, has -- received any services from a mental health community support program?</p> <p><i>Read if necessary: A community support program for clients with mental or emotional problems is a program that makes available mental health, health, social and support services based on individual need.</i></p> | | <p>13. <input type="checkbox"/> Yes } (E2 for NP, or Part F on page 106) <input type="checkbox"/> No } <input type="checkbox"/> DK }</p> | <p>45</p> |

Section II - DISABILITY - Continued

Part F - SERVICES AND BENEFITS

RT 73

3-4

PERSON 1

1a. Some programs help people with disabilities to develop skills and opportunities for paid employment. During the past 12 months, did (read names of persons 18+) participate in a sheltered workshop, transitional work training, or supported employment?

- 1a.**
 1 Yes (1b)
 2 No } (1d)
 9 DK

5

b. Who is this?

Ask if necessary: In which programs did -- participate during the past 12 months, sheltered workshop, transitional work training, or supported employment?

Mark (X) appropriate box(es) in person's column.

- b.**
 1 Sheltered workshop
 2 Transitional work training
 3 Supported employment

6

7

8

c. Did anyone else participate in any of these programs during the past 12 months?

- Yes (Reask 1b and c) No (1d)

d. Are (names of persons 18+) now on a waiting list for any of these programs?

- d.**
 1 Yes (1e)
 2 No } (2 on page 108)
 9 DK

9

e. Who is this?

- e.**
 1 Waiting list

10

f. Anyone else?

- Yes (Reask 1e and f) No (2 on page 108)

Notes

Section II - DISABILITY - Continued

Part F - SERVICES AND BENEFITS - Continued

PERSON 1

2a. During the past 12 months, did (read names of persons 18+) go to a day activity center for persons with disabilities which provides social, recreational and developmental activities during normal working hours?

- 2a.** 1 Yes (2b)
 2 No } (2d)
 9 DK }

11

b. Who is this?

Mark (X) "Day activity center" box in person's column.

b.

12

- 1 Day activity center

c. Anyone else?

- Yes (Reask 2b and c) No (2d)

d. Are (names of persons 18+) now on a waiting list for a day activity center?

- d.** 1 Yes (2e)
 2 No } (3 on page 110)
 9 DK }

13

e. Who is this?

Mark (X) "Waiting list" box in person's column.

e.

14

- 1 Waiting list

f. Anyone else?

- Yes (Reask 2e and f) No (3 on page 110)

Notes

Section II - DISABILITY - Continued

Part F - SERVICES AND BENEFITS - Continued

PERSON 1

| | |
|---|--|
| <p>3a. During the past 12 months, have <u>(names of persons 18+)</u> received any physical therapy?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Physical therapy" box in person's column.</i> <i>Ask 3c-d for each person with box marked in 3b.</i></p> <p>-----</p> <p>c. Has the condition for which -- gets physical therapy been going on or is it expected to go on for at least 12 months?</p> <p>-----</p> <p>d. What is the main condition for which -- gets physical therapy?</p> | <p>3a. 15 <input type="checkbox"/> Yes (3b) <input type="checkbox"/> No } (4a) <input type="checkbox"/> DK }</p> <hr/> <p>b. 16 <input type="checkbox"/> Physical therapy</p> <hr/> <p>c. 17 <input type="checkbox"/> Yes (3d) <input type="checkbox"/> No } (NP with 3b, or 4) <input type="checkbox"/> DK }</p> <hr/> <p>d. 18 <i>(Enter condition in X1 and mark box)</i> <input type="checkbox"/> In C2 } (3c for NP with <input type="checkbox"/> Not in C2 } 3b, or 4)</p> |
| <p>4a. During the past 12 months, have <u>(names of persons 18+)</u> received any occupational therapy?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Occupational therapy" box in person's column.</i> <i>Ask 4c-d for each person with box marked in 4b.</i></p> <p>-----</p> <p>c. Has the condition for which -- gets occupational therapy been going on or is it expected to go on for at least 12 months?</p> <p>-----</p> <p>d. What is the main condition for which -- gets occupational therapy?</p> | <p>4a. 19 <input type="checkbox"/> Yes (4b) <input type="checkbox"/> No } (5 on page 112) <input type="checkbox"/> DK }</p> <hr/> <p>b. 20 <input type="checkbox"/> Occupational therapy</p> <hr/> <p>c. 21 <input type="checkbox"/> Yes (4d) <input type="checkbox"/> No } (NP with 4b, or 5 on <input type="checkbox"/> DK } page 112)</p> <hr/> <p>d. 22 <i>(Enter condition in X1 and mark box)</i> <input type="checkbox"/> In C2 } (4c for NP with <input type="checkbox"/> Not in C2 } 4b, or 5 on page 112)</p> |

Notes

Section II - DISABILITY - Continued

Part F - SERVICES AND BENEFITS - Continued

PERSON 1

| | | | |
|--|------------|---|----|
| <p>Vocational rehabilitation provides equipment and services to people with disabilities to improve their ability to work or live independently.</p> <p>5a. Have (read names of persons 18+) EVER received any equipment or services through vocational rehabilitation?</p> <p>b. Who is this?</p> <p><i>Mark (X) "Vocational rehabilitation" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No (6)</p> | 5a. | <p><input type="checkbox"/> Yes (5b) <input type="checkbox"/> No } (6) <input type="checkbox"/> DK }</p> | 23 |
| <p>A case manager coordinates personal care, and social or medical services for persons with special needs.</p> <p>6a. During the past 12 months, did (read names of persons 18+) have a case manager?</p> <p>b. Who is this?</p> <p><i>Mark (X) "Case manager" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No (7)</p> | 6a. | <p><input type="checkbox"/> Yes (6b) <input type="checkbox"/> No } (7) <input type="checkbox"/> DK }</p> | 25 |
| <p><i>Ask only for persons 18+ without 6b marked; otherwise, go to 8.</i></p> <p>7a. During the past 12 months, did (persons 18+ without 6b marked) NEED a case manager to coordinate personal care or social or medical services?</p> <p>b. Who is this?</p> <p><i>Mark (X) "Needs case manager" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 7b and c) <input type="checkbox"/> No (8)</p> | 7a. | <p><input type="checkbox"/> Yes (7b) <input type="checkbox"/> No } (8) <input type="checkbox"/> DK }</p> | 27 |
| <p>8a. Do (read names of persons 18+) have a court-appointed legal guardian?</p> <p>b. Who has a legal guardian?</p> <p><i>Mark (X) "Legal guardian" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No (Part G on page 114)</p> | 8a. | <p><input type="checkbox"/> Yes (8b) <input type="checkbox"/> No } (Part G on page 114) <input type="checkbox"/> DK }</p> | 29 |
| <p>5a. Have (read names of persons 18+) EVER received any equipment or services through vocational rehabilitation?</p> <p>b. Who is this?</p> <p><i>Mark (X) "Vocational rehabilitation" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No (6)</p> | b. | <p><input type="checkbox"/> Vocational rehabilitation</p> | 24 |
| <p>6a. During the past 12 months, did (read names of persons 18+) have a case manager?</p> <p>b. Who is this?</p> <p><i>Mark (X) "Case manager" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 6b and c) <input type="checkbox"/> No (7)</p> | b. | <p><input type="checkbox"/> Case manager</p> | 26 |
| <p>7a. During the past 12 months, did (persons 18+ without 6b marked) NEED a case manager to coordinate personal care or social or medical services?</p> <p>b. Who is this?</p> <p><i>Mark (X) "Needs case manager" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 7b and c) <input type="checkbox"/> No (8)</p> | b. | <p><input type="checkbox"/> Needs case manager</p> | 28 |
| <p>8a. Do (read names of persons 18+) have a court-appointed legal guardian?</p> <p>b. Who has a legal guardian?</p> <p><i>Mark (X) "Legal guardian" box in person's column.</i></p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 8b and c) <input type="checkbox"/> No (Part G on page 114)</p> | b. | <p><input type="checkbox"/> Legal guardian</p> | 30 |

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN

RT 74

PERSON 1

3-4

**ITEM
G1**

Refer to family composition.

G1

- 1 One or more members under 18 (1)
 2 All members 18+ (Part L on page 156)

5

The next questions refer to family members who are under 18 years old, that is (read names of nondeleted persons under 18).

1a. Do (names of persons under 18) NOW go to a medical doctor or specialist on a regular basis for anything other than routine physical exams?

1a.

- 1 Yes (1b)
 2 No } (2)
 9 DK }

6

b. Who is this?

(Anyone else?)

Mark (X) "Regular visits" box in person's column.

Ask 1c-d for each person with box marked in 1b.

b.

- 1 Regular visits

7

c. Has any problem or condition for which -- sees a doctor regularly been going on or is it expected to go on for at least 12 months?

c.

- 1 Yes (1d)
 2 No } (NP with 1b, or 2)
 9 DK }

8

Ask only if "Yes" in 1c.

d. What is the main problem or condition for which -- goes to a doctor regularly?

d.

- (Enter condition in X1 and mark box)
 1 In C2 } (1c for NP with
 2 Not in C2 } 1b, or 2)

9

2a. Do you think that (names of persons under 18) have any significant problems or delays in physical development?

2a.

- 1 Yes (2b)
 2 No } (3 on page 116)
 9 DK }

10

b. Who is this?

(Anyone else?)

Mark (X) "Problem or delay" box in person's column.

Ask 2c for each person with box marked in 2b.

b.

- 1 Problem or delay

11

c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in physical development?

c.

- 1 Yes } (NP with 2b, or 3
 2 No } on page 116)
 9 DK }

12

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

| | |
|--|---|
| <p>3a. Do (names of persons under 18) NOW have a physical, mental, or emotional problem for which they regularly take prescription medication?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Prescription medication" box in person's column.</i> <i>Ask 3c-d for each person with box marked in 3b.</i></p> <p>-----</p> <p>c. Has the problem or condition for which -- regularly takes prescription medication been going on or is it expected to go on for at least 12 months?</p> <p><i>Ask only if "Yes" in 3c.</i></p> <p>-----</p> <p>d. What is the main problem or condition for which -- regularly takes prescription medication?</p> | <p>3a. 13 <input type="checkbox"/> Yes (3b) <input type="checkbox"/> No } (4) <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 14 <input type="checkbox"/> Prescription medication</p> <p>-----</p> <p>c. 15 <input type="checkbox"/> Yes (3d) <input type="checkbox"/> No } (NP with 3b, or 4) <input type="checkbox"/> DK }</p> <p>-----</p> <p>d. 16 <i>(Enter condition in X1 and mark box)</i> <input type="checkbox"/> In C2 } (3c for NP with <input type="checkbox"/> Not in C2 } 3b, or 4)</p> |
| <p>4a. Has (names of persons under 18) ever been a patient in a hospital overnight for a physical, mental, or emotional condition that they STILL HAVE or GET FROM TIME TO TIME?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Hospital overnight" box in person's column.</i> <i>Ask 4c-d for each person with box marked in 4b.</i></p> <p>-----</p> <p>c. Has the problem or condition for which -- was hospitalized been going on or is it expected to go on for at least 12 months?</p> <p><i>Ask only if "Yes" in 4c.</i></p> <p>-----</p> <p>d. What is the main condition which caused -- hospitalization(s)?</p> | <p>4a. 17 <input type="checkbox"/> Yes (4b) <input type="checkbox"/> No } (5) <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 18 <input type="checkbox"/> Hospital overnight</p> <p>-----</p> <p>c. 19 <input type="checkbox"/> Yes (4d) <input type="checkbox"/> No } (NP with 4b, or 5) <input type="checkbox"/> DK }</p> <p>-----</p> <p>d. 20 <i>(Enter condition in X1 and mark box)</i> <input type="checkbox"/> In C2 } (4c for NP with <input type="checkbox"/> Not in C2 } 4b, or 5)</p> |
| <p>5a. Do (names of persons under 18) NOW have any life-threatening allergic reactions to any foods?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Allergic reaction" box in person's column.</i></p> | <p>5a. 21 <input type="checkbox"/> Yes (5b) <input type="checkbox"/> No } (6 on page 118) <input type="checkbox"/> DK }</p> <p>-----</p> <p>b. 22 <input type="checkbox"/> Allergic reaction</p> |

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

| | |
|---|---|
| <p>6a. Are (names of persons under 18) following a special diet ordered by a doctor because of a serious ongoing medical condition?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Special diet" box in person's column.</i> <i>Ask 6c-d for each person with box marked in 6b.</i></p> <p>-----</p> <p>c. Would going off this diet cause -- to have a serious life-threatening reaction or illness?</p> <p>-----</p> <p><i>Ask only if "Yes" in 6c.</i></p> <p>d. What is the main problem or condition for which -- follows a special diet?</p> | <p>6a. 23</p> <p>1 <input type="checkbox"/> Yes (6b) 2 <input type="checkbox"/> No } (7) 9 <input type="checkbox"/> DK }</p> <hr/> <p>b. 24</p> <p>1 <input type="checkbox"/> Special diet</p> <hr/> <p>c. 25</p> <p>1 <input type="checkbox"/> Yes (6d) 2 <input type="checkbox"/> No } (NP with 6b, or 7) 9 <input type="checkbox"/> DK }</p> <hr/> <p>d. 26</p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (6c for NP with 2 <input type="checkbox"/> Not in C2 } 6b, or 7)</p> |
|---|---|

| | |
|--|--|
| <p>7a. Do (names of persons under 18) NOW need special medical equipment in order to breathe?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Special equipment" box in person's column.</i> <i>Ask 7c-d for each person with box marked in 7b.</i></p> <p>-----</p> <p>c. Has the problem or condition for which -- needs this equipment been going on or is it expected to go on for at least 12 months?</p> <p>-----</p> <p><i>Ask only if "Yes" in 7c.</i></p> <p>d. What is the main problem or condition for which -- needs medical equipment in order to breathe?</p> | <p>7a. 27</p> <p>1 <input type="checkbox"/> Yes (7b) 2 <input type="checkbox"/> No } (8 on page 120) 9 <input type="checkbox"/> DK }</p> <hr/> <p>b. 28</p> <p>1 <input type="checkbox"/> Special equipment</p> <hr/> <p>c. 29</p> <p>1 <input type="checkbox"/> Yes (7d) 2 <input type="checkbox"/> No } (NP with 7b, or 8 9 <input type="checkbox"/> DK } on page 120)</p> <hr/> <p>d. 30</p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (7c for NP with 2 <input type="checkbox"/> Not in C2 } 7b, or 8 on page 120)</p> |
|--|--|

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

8a. Do (names of persons under 18) NOW go to a counselor, psychiatrist, psychologist, or social worker on a regular basis?

8a.

- 1 Yes (8b)
 2 No } (9)
 9 DK }

31

b. Who is this?

(Anyone else?)

Mark (X) "Counselor" box in person's column.

Ask 8c for each person with box marked in 8b.

b.

- 1 Counselor

32

c. Has -- counseling gone on or is it expected to go on for at least 12 months?

c.

- 1 Yes } (NP with 8b, or 9)
 2 No }
 9 DK }

33

9a. During the past 12 months, have (names of persons under 18) received any physical therapy?

9a.

- 1 Yes (9b)
 2 No } (10 on page 122)
 9 DK }

34

b. Who is this?

(Anyone else?)

Mark (X) "Physical therapy" box in person's column.

Ask 9c-d for each person with box marked in 9b.

b.

- 1 Physical therapy

35

c. Has the problem or condition for which -- gets physical therapy been going on or is it expected to go on for at least 12 months?

c.

- 1 Yes (9d)
 2 No } (NP with 9b, or 10
 9 DK } on page 122)

36

Ask only if "Yes" in 9c.

d. What is the main problem or condition for which -- gets physical therapy?

d.

- (Enter condition in X1 and mark box)
 1 In C2 } (9c for NP with
 2 Not in C2 } 9b, or 10 on page
 122)

37

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

| | |
|---|--|
| <p>10a. During the past 12 months, have (names of persons under 18) received any occupational therapy?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) Mark (X) "Occupational therapy" box in person's column. Ask 10c-d for each person with box marked in 10b.</p> <p>-----</p> <p>c. Has the problem or condition for which -- gets occupational therapy been going on or is it expected to go on for at least 12 months? Ask only if "Yes" in 10c.</p> <p>-----</p> <p>d. What is the main problem or condition for which -- gets occupational therapy?</p> | <p>10a. 38 1 <input type="checkbox"/> Yes (10b) 2 <input type="checkbox"/> No } (Item G2) 9 <input type="checkbox"/> DK</p> <p>-----</p> <p>b. 39 1 <input type="checkbox"/> Occupational therapy</p> <p>-----</p> <p>c. 40 1 <input type="checkbox"/> Yes (10d) 2 <input type="checkbox"/> No } (NP with 10b, or G2) 9 <input type="checkbox"/> DK</p> <p>-----</p> <p>d. 41 (Enter condition in X1 and mark box) 1 <input type="checkbox"/> In C2 } (10c for NP with 2 <input type="checkbox"/> Not in C2 } 10b, or G2</p> |
|---|--|

| | | |
|----------------|--|--|
| ITEM G2 | <p>Refer to age or 9c and 10c for each person.</p> | <p>G2 42 2 <input type="checkbox"/> 18+ (NP, or 14 on page 132) 1 <input type="checkbox"/> Yes in 9c or 10c (11) 2 <input type="checkbox"/> Other (NP, or 14 on page 132)</p> |
|----------------|--|--|

| | |
|---|--|
| <p>11a. Does -- NOW receive any physical or occupational therapy AT HOME? THIS INCLUDES THERAPY GIVEN BY YOU, OTHER FAMILY MEMBERS, FRIENDS, VOLUNTEERS, OR PAID PROFESSIONALS.</p> <p>-----</p> <p>b. What are the names of all persons who give -- therapy at home? Ask 11c and d only if 4 names were entered in Table T; otherwise, go to 11e in Table T.</p> <p>-----</p> <p>c. Are there any other persons who give -- physical or occupational therapy at home?</p> <p>-----</p> <p>d. How many others?</p> | <p>11a. 43 1 <input type="checkbox"/> Yes (11b) 2 <input type="checkbox"/> No } (12 on page 128) 9 <input type="checkbox"/> DK</p> <p>-----</p> <p>b. 44 (Record up to 4 names in Table T on page 124, then return to 11c)</p> <p>-----</p> <p>c. 45-46 1 <input type="checkbox"/> Yes (11d) 2 <input type="checkbox"/> No } (11e in Table T on page 124) 9 <input type="checkbox"/> DK</p> <p>-----</p> <p>d. 45-46 Therapist(s) (Number) (11e in Table T on page 124)</p> |
|---|--|

Notes

Section II - DISABILITY - Continued

RT 75

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

THERAPIST AT HOME

TABLE T

Child's name

Child's number

3-4

Therapist name

5-6

11e. Does (therapist) do physical or occupational therapy with --?

11e.

- 1 Physical
- 2 Occupational
- 3 Both
- 9 DK

7

HAND CARD DG1. Read categories if telephone interview.

f. What is (therapist) relationship to --?

Mark (X) only one.

f.

- 0 Parent (11k)
 - 1 Other relative who lives here
 - 2 Other relative who does not live here
 - 3 Non-relative who lives here
 - 4 Friend/neighbor
 - 5 Unpaid volunteer from an organization or business (11j)
 - 6 Paid employee of an organization or business
 - 7 Paid employee of yours
 - 8 Other
 - 9 DK
- (11g) }
(11h) }

8

g. Is this therapy paid for?

g.

- 1 Yes (11h on page 126)
 - 2 No
 - 9 DK
- (11j on page 126) }

9

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

THERAPIST AT HOME

TABLE T - Continued

HAND CARD DG2. Read categories if telephone interview.

11h. Who pays for this therapy?

(Anyone else?)

Mark (X) all that apply.

- | | | |
|-------------|---|-------|
| 11h. | 00 <input type="checkbox"/> Parent | 10-11 |
| | 01 <input type="checkbox"/> Other family member in HH | 12-13 |
| | 02 <input type="checkbox"/> Other family member not in HH | 14-15 |
| | 03 <input type="checkbox"/> Private insurance | 16-17 |
| | 04 <input type="checkbox"/> Rehabilitation program | 18-19 |
| | 05 <input type="checkbox"/> Medicaid | 20-21 |
| | 06 <input type="checkbox"/> Public school system | 22-23 |
| | 07 <input type="checkbox"/> Other public source | 24-25 |
| | 08 <input type="checkbox"/> Other private source | 26-27 |
| | 09 <input type="checkbox"/> Other | 28-29 |
| | 99 <input type="checkbox"/> DK or Refused | 30-31 |

Ask 11i only if box 00 or 01 is marked in 11h; otherwise, skip to 11j.

i. How much did [you/the family] pay for this therapy during the past 2 weeks? Do not count money that will be reimbursed by insurance, an HMO, or other source.

If none, enter 0; otherwise, enter amount in whole dollars.

i. \$ _____
(Dollars) 32-35

j. How satisfied are you with this therapy? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

If respondent is not a parent or guardian, explain, if necessary, that "you" refers to the family in general.

- j.** 36
- | |
|--|
| 1 <input type="checkbox"/> Very satisfied |
| 2 <input type="checkbox"/> Somewhat satisfied |
| 3 <input type="checkbox"/> Somewhat dissatisfied |
| 4 <input type="checkbox"/> Very dissatisfied |
| 9 <input type="checkbox"/> DK |

k. How many days during the past 2 weeks did (therapist) work with -- ?

- k.** 37-38
- 00 None in past 2 weeks
- _____ Days
(Number)

l. Please estimate the hours per day that (therapist) did therapy with -- . Include therapy that is part of another activity such as play.

- l.** 39-40
- _____ Hours/Day
- 00 Less than 1 hour/day

If another therapist in Table T for this person, ask 11e on page 124 for the next therapist; otherwise, continue with 12a on page 128 for this person.

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

RT 76

3-4

PERSON 1

12a. Does -- receive any physical or occupational therapy at any other place, that is, OTHER THAN AT HOME?

12a.

- 1 Yes (12b)
 2 No
 9 DK } (G2 on page 122 for NP, or 14 on page 132)

5

b. Does -- receive this therapy at school, at a location other than school or both places?

Mark (X) only one.

b.

- 1 School (12c)
 2 Location other than school (13 on page 130)
 3 Both (12c)

6

c. Is the therapy -- receives at school physical therapy, occupational therapy or both?

Mark (X) only one.

c.

- 1 Physical therapy
 2 Occupational therapy
 3 Both

7

**ITEM
G3**

Refer to 12b for this person.

G3

- 1 School only (G2 on page 122 for NP, or 14 on page 132)
 2 All others (13 on page 130)

8

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

These questions are about therapy that -- receives OTHER THAN AT HOME AND AT SCHOOL.

9

13a. Is this physical therapy, occupational therapy, or both?

Mark (X) only one.

- 13a.** 1 Physical therapy
 2 Occupational therapy
 3 Both

b. During the past 2 weeks how often did -- receive [physical/(and)occupational] therapy NOT COUNTING THERAPY AT HOME OR SCHOOL?

SHOW CARD DG2. Read categories if telephone interview.

c. Who pays for this therapy?

Mark (X) all that apply.

- b.** 00 None 10-11

____ Times
(Number)

- c.**
- 00 Parent 12-13
 - 01 Other family member in HH 14-15
 - 02 Other family member not in HH 16-17
 - 03 Private insurance 18-19
 - 04 Rehabilitation program 20-21
 - 05 Medicaid 22-23
 - 06 Public school system 24-25
 - 07 Other public source 26-27
 - 08 Other private source 28-29
 - 09 Other 30-31
 - 99 DK or Refused 32-33

Ask 13d only if box 00 or 01 is marked in 13c; otherwise, skip to 13e.

d. How much did [you/the family] pay for this therapy during the past 2 weeks. Do not count money that will be reimbursed by insurance, an HMO, or other source.

If none, enter 0; otherwise enter amount in whole dollars.

d. \$ _____
(Dollars)

e. How satisfied are you with this therapy? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

If respondent is not a parent or guardian, explain, if necessary, that "you" refers to the family in general.

- e.** 38
- 1 Very satisfied
 - 2 Somewhat satisfied
 - 3 Somewhat dissatisfied
 - 4 Very dissatisfied
- (G2 on page 122 for NP, or 14 on page 132)*

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

| | |
|---|--|
| <p>14a. (Besides physical or occupational therapy) do (names of persons under 18) NOW have any (other) medical or health procedures done AT HOME?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Medical Procedures" box in person's column.</i> <i>Ask 14c - d for each person with box marked in 14b.</i></p> <p>c. Has the problem or condition for which -- has (other) medical procedures done AT HOME been going on or is it expected to go on for at least 12 months?</p> <p>-----</p> <p><i>Ask only if "Yes" in 14c.</i></p> <p>d. What is the main problem or condition for which -- gets medical procedures done AT HOME?</p> | <p>14a. 39</p> <p>1 <input type="checkbox"/> Yes (14b) 2 <input type="checkbox"/> No } (Item G4) 9 <input type="checkbox"/> DK }</p> <hr/> <p>b. 40</p> <p>1 <input type="checkbox"/> Medical procedures</p> <hr/> <p>c. 41</p> <p>1 <input type="checkbox"/> Yes (14d) 2 <input type="checkbox"/> No } (NP with 14b, or G4) 9 <input type="checkbox"/> DK }</p> <hr/> <p>d. 42</p> <p>(Enter condition in X1 and mark box)</p> <p>1 <input type="checkbox"/> In C2 } (14c for NP with 2 <input type="checkbox"/> Not in C2 } 14b, or G4)</p> |
| <p>ITEM G4 43</p> <p><i>Refer to ages of all family members.</i></p> | <p>G4 43</p> <p>1 <input type="checkbox"/> Any 1-17 years (15) 2 <input type="checkbox"/> All others (Item G6 on page 136)</p> |
| <p>15a. Do you think that (names of persons 1-17 years old) NOW have any problems or delays in understanding things, that is, delays in cognitive or mental development?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Mental development" box in person's column.</i> <i>Ask 15c for each person with box marked in 15b.</i></p> <p>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in understanding things?</p> | <p>15a. 44</p> <p>1 <input type="checkbox"/> Yes (15b) 2 <input type="checkbox"/> No } (16) 9 <input type="checkbox"/> DK }</p> <hr/> <p>b. 45</p> <p>1 <input type="checkbox"/> Mental development</p> <hr/> <p>c. 46</p> <p>1 <input type="checkbox"/> Yes } (NP with 15b, or 16) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }</p> |
| <p>16a. Do you think that (names of persons 1-17 years old) NOW have any problems or delays in speech or language development?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Speech" box for each appropriate person.</i> <i>Ask 16c for each person with box marked in 16b.</i></p> <p>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in speech or language development?</p> | <p>16a. 47</p> <p>1 <input type="checkbox"/> Yes (16b) 2 <input type="checkbox"/> No } (17 on page 134) 9 <input type="checkbox"/> DK }</p> <hr/> <p>b. 48</p> <p>1 <input type="checkbox"/> Speech</p> <hr/> <p>c. 49</p> <p>1 <input type="checkbox"/> Yes } (NP with 16b, or 17 2 <input type="checkbox"/> No } on page 134) 9 <input type="checkbox"/> DK }</p> |

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

| | |
|--|--|
| <p>17a. Do you think that (names of persons 1-17 years old) NOW have any problems or delays in emotional or behavioral development?</p> | <p>17a. <input type="checkbox"/> Yes (17b) 50 <input type="checkbox"/> No } (Item G5) <input type="checkbox"/> DK }</p> |
| <p>b. Who is this? (Anyone else?) <i>Mark (X) "Behavior" box in person's column.</i> <i>Ask 17c for each person with box marked in 17b.</i></p> | <p>b. <input type="checkbox"/> Behavior 51</p> |
| <p>c. Have any doctors or health care professionals discussed or mentioned -- problem or delay in emotional or behavioral development?</p> | <p>c. <input type="checkbox"/> Yes } (NP with 17b, or G5) <input type="checkbox"/> No } <input type="checkbox"/> DK } 52</p> |

| | | |
|----------------|---|--|
| ITEM G5 | <i>Refer to ages of all family members.</i> | <p>G5 <input type="checkbox"/> Any 2-17 (18) 53 <input type="checkbox"/> Others (Item G6 on page 136)</p> |
|----------------|---|--|

| | |
|--|--|
| <p>18a. Because of a physical, mental, or emotional problem, do (names of persons 2-17 years old) NOW have any difficulty participating in strenuous activity, such as running or swimming, compared to other children their age?</p> | <p>18a. <input type="checkbox"/> Yes (18b) 54 <input type="checkbox"/> No } (19 on page 136) <input type="checkbox"/> DK }</p> |
| <p>b. Who is this? (Anyone else?) <i>Mark (X) "Activity" box in person's column.</i> <i>Ask 18c-d for each person with box marked in 18b.</i></p> | <p>b. <input type="checkbox"/> Activity 55</p> |
| <p>c. Has the problem or condition which causes -- to have difficulty participating in strenuous activity been going on or is it expected to go on for at least 12 months?</p> <p><i>Ask only if "Yes" in 18c.</i></p> | <p>c. <input type="checkbox"/> Yes (18d) 56 <input type="checkbox"/> No } (NP with 18b, or 19 <input type="checkbox"/> DK } on page 136)</p> |
| <p>d. What is the main problem or condition which causes -- to have difficulty participating in strenuous activity?</p> | <p>d. (Enter condition in X1 and mark box) 57 <input type="checkbox"/> In C2 } (18c for NP with <input type="checkbox"/> Not in C2 } 18b, or 19 on page 136)</p> |

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

| | |
|---|---|
| <p>19a. Because of a physical, mental, or emotional problem, do (names of persons 2-17 years old) NOW have any difficulty playing or getting along with others their age?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Getting along" box in person's column.</i></p> <p>-----</p> <p><i>Ask 19c-d for each person with box marked in 19b.</i></p> <p>c. Has the problem or condition which causes -- to have difficulty getting along with others been going on or is it expected to go on for at least 12 months?</p> <p>-----</p> <p><i>Ask only if "Yes" in 19c.</i></p> <p>d. What is the main problem or condition which causes -- to have difficulty getting along with others?</p> | <p>19a. <input type="checkbox"/> Yes (19b) <input type="checkbox"/> No } (Item G6) <input type="checkbox"/> DK } 58</p> <hr style="border-top: 1px dashed black;"/> <p>b. <input type="checkbox"/> Getting along 59</p> <hr style="border-top: 1px dashed black;"/> <p>c. <input type="checkbox"/> Yes (19d) <input type="checkbox"/> No } (NP with 19b, or G6) <input type="checkbox"/> DK } 60</p> <hr style="border-top: 1px dashed black;"/> <p>d. (Enter condition in X1 and mark box) <input type="checkbox"/> In C2 } (19c for NP with <input type="checkbox"/> Not in C2 } 19b, or G6) 61</p> |
|---|---|

| | | |
|----------------|---|---|
| ITEM G6 | <i>Refer to ages of all family members.</i> | <p>G6 <input type="checkbox"/> Any persons under 5 (20) <input type="checkbox"/> None under 5 (Part J on page 146) 62</p> |
|----------------|---|---|

| | |
|---|---|
| <p>20a. Do (names of persons under 5) NOW have any physical, mental, or emotional problems which makes it difficult to chew, swallow, or digest?</p> <p>-----</p> <p>b. Who is this? (Anyone else?) <i>Mark (X) "Digest" box in person's column.</i></p> <p>-----</p> <p><i>Ask 20c-d for each person with box marked in 20b.</i></p> <p>c. Has the problem or condition which causes -- to have difficulty chewing, swallowing, or digesting been going on or is it expected to go on for at least 12 months?</p> <p>-----</p> <p><i>Ask only if "Yes" in 20c.</i></p> <p>d. What is the main problem or condition which causes -- to have difficulty chewing, swallowing, or digesting?</p> | <p>20a. <input type="checkbox"/> Yes (20b) <input type="checkbox"/> No } (21 on page 138) <input type="checkbox"/> DK } 63</p> <hr style="border-top: 1px dashed black;"/> <p>b. <input type="checkbox"/> Digest 64</p> <hr style="border-top: 1px dashed black;"/> <p>c. <input type="checkbox"/> Yes (20d) <input type="checkbox"/> No } (NP with 20b, or 21 <input type="checkbox"/> DK } on page 138) 65</p> <hr style="border-top: 1px dashed black;"/> <p>d. (Enter condition in X1 and mark box) <input type="checkbox"/> In C2 } (20c for NP with <input type="checkbox"/> Not in C2 } 20b, or 21 on page 138) 66</p> |
|---|---|

Notes

Section II - DISABILITY - Continued

Part G - SPECIAL HEALTH NEEDS OF CHILDREN - Continued

PERSON 1

21a. Do (names of persons under age 5) NOW need special medical equipment to assist with eating or toileting?

21a. 1 Yes (21b) 67
 2 No } (Part H on page 140)
 9 DK }

b. Who is this?

(Anyone else?)

Mark (X) "Eating or toileting" box in person's column.

Ask 21c-d for each person with box marked in 21b.

b. 1 Eating or toileting 68

c. Has the problem or condition which causes -- to need special medical equipment been going on or is it expected to go on for at least 12 months?

Ask only if "Yes" in 21c.

c. 1 Yes (21d) 69
 2 No } (NP with 21b, or Part H
 9 DK } on page 140)

d. What is the main problem or condition which causes -- to need special medical equipment to assist with eating or toileting?

d. (Enter condition in X1 and mark box) 70
 1 In C2 } (21c for NP with
 2 Not in C2 } 21b, or Part H
on page 140)

Notes

Section II - DISABILITY - Continued
Part H - EARLY CHILD DEVELOPMENT

RT 77
3-4

PERSON 1

| | | | | |
|--|--|-----------|---|-----|
| ITEM H1 | Refer to age for each family member. | H1 | <input type="checkbox"/> 5+ (NP, or Part J on page 146) <input type="checkbox"/> Under 5 (H2) | 5 |
| ITEM H2 | Refer to child's date of birth and date of interview. Calculate age in months. | H2 | _____ Months <input type="checkbox"/> Birthdate unknown (1) | 6-7 |
| ITEM H3 | Refer to H2. | H3 | <input type="checkbox"/> Under 4 months (H1 for NP, or Part J on page 146) <input type="checkbox"/> 4-8 months (2) <input type="checkbox"/> 9-15 months (5) <input type="checkbox"/> 16-29 months (11 on page 142) <input type="checkbox"/> 30-59 months (18 on page 142) | 8 |
| <i>HAND CARD DH1. Read categories if telephone interview.</i> 1. Which age group do you think -- belongs in? | | 1. | <input type="checkbox"/> Under 4 months (H1 for NP, or Part J on page 146) <input type="checkbox"/> 4-8 months (2) <input type="checkbox"/> 9-15 months (5) <input type="checkbox"/> 16-29 months (11 on page 142) <input type="checkbox"/> 30-59 months (18 on page 142) | 9 |
| 2. Does -- usually show an interest in things around -- by looking at sights or by turning toward sounds? | | 2. | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10 |
| 3. Does -- usually seem happy or pleased when -- sees -- favorite people? | | 3. | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11 |
| 4. Can -- hold -- head up without support? | | 4. | <input type="checkbox"/> Yes } (H1 for NP, or Part J on page 146) <input type="checkbox"/> No } | 12 |
| 5. Does -- usually show an interest in things around -- by looking at sights or by turning toward sounds? | | 5. | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13 |
| 6. Does -- usually seem happy or pleased when -- sees -- favorite people? | | 6. | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14 |
| 7. Can -- sit upright without leaning against anything? | | 7. | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15 |
| 8. Has -- ever crawled or crept on hands or stomach? | | 8. | <input type="checkbox"/> Yes } (9 on page 142) <input type="checkbox"/> No } | 16 |

| Section II - DISABILITY - Continued | | |
|--|--|-----------------|
| Part H - EARLY CHILD DEVELOPMENT - Continued | | PERSON 1 |
| 9. Is -- able to show what -- wants by pointing at something, reaching out to be picked up, making special noises, or saying words? | 9. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 17 |
| 10. Does -- ever respond to people talking or playing with -- by making sounds, faces, or saying words? | 10. 1 <input type="checkbox"/> Yes } (H1 on page 140 for NP, 2 <input type="checkbox"/> No } or Part J on page 146) | 18 |
| 11. Does -- usually pay attention to things that interest -- such as toys, picture books, or a person -- likes for as long as a minute? | 11. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 19 |
| 12. Does -- usually seem happy or pleased when -- sees -- favorite people? | 12. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 20 |
| 13. Can -- sit upright without leaning against anything? | 13. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 21 |
| 14. Is -- able to show what -- wants by pointing at things, reaching out to be picked up, making special noises, or saying words? | 14. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 22 |
| 15a. Does -- walk without holding on to anything? | 15a. 1 <input type="checkbox"/> Yes (16) 2 <input type="checkbox"/> No (15b) | 23 |
| b. Has -- ever crawled or crept on hands or stomach? | b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 24 |
| 16. Is -- able to show what -- wants or needs by using actions or words, such as leading you by the hand to open a door or saying words like "juice" or "that"? | 16. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 25 |
| 17. Does -- ever respond to people talking or playing with -- by making sounds or faces or by saying words? | 17. 1 <input type="checkbox"/> Yes } (H1 on page 140 for NP, 2 <input type="checkbox"/> No } or Part J on page 146) | 26 |
| 18. Does -- usually pay attention for as long as a minute to things that interest --, such as toys, picture books, or a person -- likes? | 18. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 27 |
| 19. Does -- usually seem happy or pleased when -- sees -- favorite people? | 19. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28 |
| 20. Does -- walk rapidly or run? | 20. 1 <input type="checkbox"/> Yes (22 on page 144) 2 <input type="checkbox"/> No (21 on page 144) | 29 |

Section II - DISABILITY - Continued

Part H - EARLY CHILD DEVELOPMENT - Continued

PERSON 1

| | |
|--|---|
| <p>21a. Does -- walk without holding on to anything?</p> <p>-----</p> <p>b. Has -- ever crawled or crept on hands or stomach?</p> <p>-----</p> <p>c. Can -- sit upright without leaning against anything?</p> | <p>21a. <input type="checkbox"/> Yes (22) 30 <input type="checkbox"/> No (21b)</p> <p>b. <input type="checkbox"/> Yes 31 <input type="checkbox"/> No</p> <p>c. <input type="checkbox"/> Yes 32 <input type="checkbox"/> No</p> |
| <p>22. Is -- able to show what -- wants or needs by using actions, or words, such as leading you by the hand to open a door or saying words like "juice" or "that" or talking?</p> | <p>22. <input type="checkbox"/> Yes 33 <input type="checkbox"/> No</p> |
| <p>23a. Does -- talk in phrases or sentences most of the time?</p> <p>-----</p> <p>b. Is -- able to show that -- likes or dislikes something by actions such as shaking -- head or using gestures?</p> | <p>23a. <input type="checkbox"/> Yes (25) 34 <input type="checkbox"/> No (24) <input type="checkbox"/> Child is deaf (23b)</p> <p>b. <input type="checkbox"/> Yes } (25) 35 <input type="checkbox"/> No }</p> |
| <p>24. Is -- able to use words to show what -- likes or dislikes, such as "want that" or "no want"?</p> | <p>24. <input type="checkbox"/> Yes } (25) 36 <input type="checkbox"/> No }</p> |
| <p>25. Does -- ever play "make believe," such as feeding a doll, playing house, or pretending to be a TV or movie superstar?</p> | <p>25. <input type="checkbox"/> Yes 37 <input type="checkbox"/> No</p> |
| <p>26. Can -- play with another person? For example, can -- help another person build with blocks or feed a baby doll?</p> | <p>26. <input type="checkbox"/> Yes } (H1 on page 140 for NP, 38 <input type="checkbox"/> No } or Part J on page 146)</p> |

Notes

Section II - DISABILITY - Continued

Part J - EDUCATION

PERSON 1

RT 78

3-4

5

**ITEM
J1**

Refer to age for each family member.

J1

- 1 Under 3 (6 on page 150)
- 2 3-17 (1)
- 3 18+ (NP, or Part K on page 152)

1a. Is -- now going to school or on vacation from school?

1a.

- 1 Yes (2 on page 148)
- 2 No (1b)

Hand Card DJ1. Read categories if telephone interview.

b. Why isn't -- going to school?

Mark (X) only one.

b.

- 1 Not old enough yet } (3 on page 148)
- 2 Illness }
- 3 Receiving home teaching by parents or others (1c)
- 4 Permanently expelled/suspended from school }
- 5 Quit school to get a job } (J1 for NP, or Part K on page 152)
- 6 Quit school for other reason }
- 7 Graduated
- 8 Other
- 9 DK

c. Is this because of a physical, mental, or emotional problem?

c.

- 1 Yes (1d)
- 2 No (J1 for NP, or Part K on page 152)

d. Has -- had this problem for at least 12 months or is -- expected to have it for 12 months?

d.

- 1 Yes (3 on page 148)
- 2 No (J1 for NP, or Part K on page 152)

Notes

Section II - DISABILITY - Continued

Part J - EDUCATION - Continued

PERSON 1

Hand Card DJ2.

10

2. Does -- have significant problems at school with -

a. Understanding instructional materials?

- a.** 1 Yes
 2 No
 3 Can't do or does not apply because of limitation

b. Paying attention in class?

- b.** 1 Yes
 2 No
 3 Can't do or does not apply because of limitation

c. Following rules or controlling [his/her] behavior?

- c.** 1 Yes
 2 No
 3 Can't do or does not apply because of limitation

d. Communicating with teachers and other students?

- d.** 1 Yes
 2 No
 3 Can't do or does not apply because of limitation

{Special education is teaching designed to meet the individual needs of a child with special needs. It is paid for by the public school system and may take place at a regular school, a special school, a private school, at home, or at a hospital.}

14

3. Is -- now receiving special education services? Do not include gifted or talented programs.

- 3.** 1 Yes
 2 No
 9 DK

{An IEP, or Individual Education Plan, is a written plan for a child with special needs, describing what that child will learn.}

15

4. Does -- now have an Individual Education Plan or IEP?

- 4.** 1 Yes
 2 No
 9 DK

5. Does -- attend a special school or day camp for children with special needs?

- 5.** 1 Yes
 2 No
 9 DK

(J1 on page 146 for NP, or Part K on page 152)

16

Notes

Section II - DISABILITY - Continued

Part J - EDUCATION - Continued

PERSON 1

{Early Intervention Services are services designed to meet the needs of very young children with special needs. They are provided by the State or school system at no cost to the parent.}

17

6. Does -- now receive Early Intervention Services?

- 6.** 1 Yes
 2 No
 9 DK

{An Individual Family Service Plan (IFSP) is a written plan of goals and services for young children with special needs and their families.}

18

7. Does -- now have an Individual Family Service Plan or IFSP?

- 7.** 1 Yes
 2 No
 9 DK

**ITEM
J2**

Refer to this child's age.

19

J2

- 1 1-2 years (8)
 2 Other (J1 on page 146 for NP, or Part K on page 152)

8. Does -- now attend a special school or day camp for children with special needs?

20

8.

- 1 Yes } (J1 on page 146 for NP,
 2 No } or Part K on page 152)

Notes

Section II - DISABILITY - Continued

Part K - RELATIONSHIPS TO RESPONDENT

RT 79

PERSON 1

3-4

**ITEM
K1**

Enter person number of respondent for each family member.

K1

5-6

Person number _____

**ITEM
K2**

Refer to each person's age.

K2

7

- 1 18+ (NP)
- 2 Under 18 (1)

Verify or ask:

1a. How are you related to --?

Mark (X) only one.

1a.

8

- 1 Mother } (1b)
- 2 Father } (1b)
- 3 Brother/Sister (1d)
- 4 Grandparent } (2 on page 154)
- 5 Other relative } (2 on page 154)
- 6 Nonrelative } (K1 for NP, or Part L on page 156)
- 7 Self } (K1 for NP, or Part L on page 156)
- 8 Spouse } (156)

b. Are you -- biological or natural, adoptive, step, or foster parent?

Mark (X) only one.

b.

9

- 1 Biological/Natural } (2 on page 154)
- 2 Adoptive } (1c)
- 3 Step } (1c)
- 4 Foster } (1c)

c. How old was -- when -- first started living with you?

c.

10-12

- _____ { 1 Months } (2 on page 154)
- _____ { 2 Years } (2 on page 154)
- 000 Since birth
- 999 DK

d. Are you -- full, half, step, adoptive, or foster [brother/sister]?

Mark (X) only one.

d.

13

- 1 Full } (2 on page 154)
- 2 Half } (2 on page 154)
- 3 Step } (2 on page 154)
- 4 Adoptive } (2 on page 154)
- 5 Foster } (2 on page 154)

Notes

Section II - DISABILITY - Continued

Part K - RELATIONSHIPS TO RESPONDENT - Continued

PERSON 1

2a. Are you the person in the household who knows the MOST about -- health?

2a.

14

- 1 Yes (K1 on page 152 for NP, or Part L on page 156)
 2 No (2b)

b. Who in the household knows the MOST about -- health?

Enter name and person number, or mark (X) box.

b.

15-16

99 No one in household or DK

Person number _____

First name _____

17-36

Last name _____

37-56

(K1 on page 152 for NP, or Part L on page 156)

Notes

Section II - DISABILITY - Continued

Part L - PERCEIVED DISABILITY

| | | |
|---|--|--|
| | | RT 80 |
| | | 3-4 |
| PERSON 1 | | |
| 1a. Do you consider yourself (or anyone in your family) to have a disability? ----- b. Who is this? Mark (X) "Respondent-perceived disability" box in person's column. ----- c. Anyone else? | 1a. 1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No } (2) 9 <input type="checkbox"/> DK } b. 1 <input type="checkbox"/> Respondent-perceived disability | 5 6 |
| <input type="checkbox"/> Yes (Reask 1b and c) <input type="checkbox"/> No (2) | | |
| 2a. Would other people consider you (or anyone in the family) to have a disability? ----- b. Who would others consider to have a disability? Mark (X) "Others perceived disability" box in person's column. ----- c. Anyone else? | 2a. 1 <input type="checkbox"/> Yes (2b) 2 <input type="checkbox"/> No } (L1) 9 <input type="checkbox"/> DK } b. 1 <input type="checkbox"/> Others perceived disability | 7 8 |
| <input type="checkbox"/> Yes (Reask 2b and c) <input type="checkbox"/> No (L1) | | |
| ITEM L1 | Enter person number(s) of respondent(s) for Section II, Disability. | L1 Person number(s) of respondents |
| 9-10 11-12 | | |
| Review X1 for each person. If a condition is also in C2 on the HIS-1, enter the condition NUMBER in the triangular space. If it is not in C2, complete a Disability Condition Page in Part M for it and enter the condition LETTER in the triangular space. | | |
| Notes | | |

Section II - DISABILITY - Continued

RT 31 3-4 5-6

Part M - CONDITION A

7

PERSON NO. _____

1. Name of condition 8

2. When did [--/anyone] last see or talk to a doctor or assistant about -- (condition)?

- | | |
|---|--|
| <input type="checkbox"/> Interview week (Reask 2) | <input type="checkbox"/> 2 yrs., less than 5 yrs. 9 |
| <input type="checkbox"/> 2-wk. ref. pd. | <input type="checkbox"/> 5 yrs. or more |
| <input type="checkbox"/> Over 2 weeks, less than 6 mos. | <input type="checkbox"/> Dr. seen, DK when |
| <input type="checkbox"/> 6 mos., less than 1 yr. | <input type="checkbox"/> DK if Dr. seen |
| <input type="checkbox"/> 1 yr., less than 2 yrs. | <input type="checkbox"/> Dr. never seen } (3b) |

3a. Did the doctor or assistant call the (condition) by a more technical or specific name? 10

- Yes No DK

Ask 3b if "Yes" in 3a, otherwise transcribe condition name from item 1 without asking: 11-14

b. What did he or she call it? 15

- (Specify)
- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Color Blindness (NC) | <input type="checkbox"/> Cancer (3e) | 16 |
| <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | <input type="checkbox"/> Old age (NC) | |
| | <input type="checkbox"/> Other (3c) | |

c. What was the cause of -- (condition in 3b)? (Specify)

Mark box if accident or injury. Accident/injury (Probe, then 5)

d. Did the (condition in 3b) result from an accident or injury? 17

- Yes (Probe, then 5) No

Ask as necessary. Record responses in 3c: (How did the accident happen?) (What was -- doing at the time of the injury?)

Ask 3e if the condition name in 3b includes any of the following words:

| | | | | | |
|---------|--------|-----------|----------|---------|---------|
| Ailment | Attack | Condition | Disease | Measles | Trouble |
| Anemia | Bad | Cyst | Disorder | Problem | Tumor |
| Asthma | Cancer | Defect | Growth | Rupture | Ulcer |

e. What kind of (condition in 3b) is it? 19

(Specify)

Ask 3f only if allergy or stroke in 3b-e:

f. How does the [allergy/stroke] NOW affect --? (Specify)

Ask 3g if there is an impairment (refer to Card CP2) or any of the following entries in 3b-f:

| | | |
|-----------------------------|--------------|----------------|
| Abscess | Growth | Rupture |
| Ache (except head or ear) | Hemorrhage | Sore(ness) |
| Bleeding (except menstrual) | Infection | Stiff(ness) |
| Blood clot | Inflammation | Tumor |
| Boil | Neuralgia | Ulcer |
| Cancer | Neuritis | Varicose veins |
| Cramps (except menstrual) | Pain | Weak(ness) |
| Cyst | Palsy | |
| Damage | Paralysis | |

g. What part of the body is affected? (Specify)

Show the following detail:

- Head skull, scalp, face
- Back/spine/vertebrae upper, middle, lower
- Side left or right
- Ear inner or outer; left, right, or both
- Eye left, right, or both
- Arm shoulder, upper, elbow, lower or wrist; left, right, or both
- Hand entire hand or fingers only; left, right, or both
- Leg hip, upper, knee, lower, or ankle; left, right, or both
- Foot entire foot, arch, or toes only; left, right, or both

Except for eyes, ears, or internal organs, ask 3h if there are any of the following entries in 3b-f:

| | | |
|-----------|------|----------|
| Infection | Sore | Soreness |
|-----------|------|----------|

h. What part of the (part of body in 3b-g) is affected by the [infection/sore/soreness] - the skin, muscle, bone, or some other part?

(Specify)

Ask if there are any of the following entries in 3b-f: 18

| | | |
|-------|------|--------|
| Tumor | Cyst | Growth |
|-------|------|--------|

4. Is this [tumor/cyst/growth] malignant or benign?

- Malignant Benign DK

5. a. When was -- (condition in 3b) first noticed? 19

- | |
|---|
| <input type="checkbox"/> 2-wk. ref. pd. |
| <input type="checkbox"/> Over 2 weeks to 3 months |
| <input type="checkbox"/> Over 3 months to 1 year |
| <input type="checkbox"/> Over 1 year to 5 years |
| <input type="checkbox"/> Over 5 years |

b. When did -- (name of injury in 3b)?

Ask probes as necessary:
 (Was it on or since (first date of 2-week ref. period) or was it before that date?)
 (Was it less than 3 months or more than 3 months ago?)
 (Was it less than 1 year or more than 1 year ago?)
 (Was it less than 5 years or more than 5 years ago?)

Section II - DISABILITY - Continued

Part M - CONDITION A - Continued

| ITEM M1 | <input type="checkbox"/> Missing extremity or organ (M2) <input type="checkbox"/> Other (12) | <p align="right">Mark box if under 18. <input type="checkbox"/> Under 18 (16) 27</p> <p>15a. Was -- under 18 when the accident happened? 1 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No</p> <p>-----</p> <p>b. Was -- in the Armed Forces when the accident happened? 2 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No</p> <p>-----</p> <p>c. Was -- at work at -- job or business when the accident happened? 3 <input type="checkbox"/> Yes 4 <input type="checkbox"/> No</p> | | | | | | | | | | | | |
|---|---|---|-------------------|----------------|--|--|--|--|-------------------|-----------------|--|--|--|--|
| 12a. Does -- still have this condition? 20 | 1 <input type="checkbox"/> Yes (M2) <input type="checkbox"/> No ----- b. Is this condition completely cured or is it under control? 2 <input type="checkbox"/> Cured 3 <input type="checkbox"/> Other (Specify) <i>z</i> 3 <input type="checkbox"/> Under control (M2) _____ (M2) | 16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? 28 | | | | | | | | | | | | |
| c. About how long did -- have this condition before it was cured? 21-23 | 000 <input type="checkbox"/> Less than 1 month OR _____ { 1 <input type="checkbox"/> Months Number 2 <input type="checkbox"/> Years | b. Was more than one vehicle involved? 29 | | | | | | | | | | | | |
| d. Was this condition present at any time during the past 12 months? 24 | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | c. Was [it/either one] moving at the time? 30 | | | | | | | | | | | | |
| ITEM M2 | <input type="checkbox"/> Not an accident/injury (NC) <input type="checkbox"/> Accident/injury (14) | 17a. At the time of the accident what part of the body was hurt? 31 | | | | | | | | | | | | |
| 14. Where did the accident happen? | 1 <input type="checkbox"/> At home (inside house) 26 2 <input type="checkbox"/> At home (adjacent premises) 3 <input type="checkbox"/> Street and highway (includes roadway and public sidewalk) 4 <input type="checkbox"/> Farm 5 <input type="checkbox"/> Industrial place (includes premises) (Specify) <i>z</i> _____ 6 <input type="checkbox"/> School (includes premises) 7 <input type="checkbox"/> Place of recreation and sports, except at school 8 <input type="checkbox"/> Other (Specify) <i>z</i> _____ | <p>What kind of injury was it? Anything else?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Part(s) of body *</th> <th style="width:50%;">Kind of injury</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> <p>-----</p> <p><i>Ask if box 3, 4, or 5 marked in Q. 5:</i></p> <p>b. What part of the body is affected now? 32 How is -- (part of body) affected? Is -- affected in any other way?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Part(s) of body *</th> <th style="width:50%;">Present effects</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> | Part(s) of body * | Kind of injury | | | | | Part(s) of body * | Present effects | | | | |
| Part(s) of body * | Kind of injury | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| Part(s) of body * | Present effects | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| * Enter part of body in same detail as for 3 g. | | | | | | | | | | | | | | |

9. Response Status

a. Section I (Immunization)

0 No child 0-5

Interview:

1 Complete } Mark (X) mode. Explain "Partial" in notes.
2 Partial }

Noninterview:

3 Refused } Explain in notes
4 Other }

Mode of interview:

All or most -

1 In person
2 By telephone

3

b. Section II (Disability)

Interview:

1 Complete } Mark (X) mode. Explain "Partial" in notes.
2 Partial }

Noninterview:

3 Refused } Explain in notes
4 Other }

Mode of interview:

All or most -

1 In person
2 By telephone

5

4

6

Notes