NOTICE – All information which would permit identification of the individual will be held in strict confidence; will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

BUDGET BUREAU NO. 68-R1600
APPROVAL EXPIRES MARCH 31, 1968

FORM NHS-HIS-4
(7-11-67)

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

Book_____ of _____ Books

U.S. HEALTH INTERVIEW SURVEY

NON-FOSDIC SUPPLEMENT

FOOTNOTES	PSU	Segment No.	Serial No.	Sample No.
				B–

INTERVIEWER CHECK ITEM

After asking Q. 10 on the Hospital Page, check one of the following boxes and follow the instructions.

☐ No hospitalizations – *Leave Doctor's and Surgeon's Bill Supplement blank*

☐ Hospitalizations – *Fill one Doctor's and Surgeon's Bill Supplement for each completed stay.*

HOSPITAL PAGE

DOCTOR'S AND SURGEON'S BILL SUPPLEMENT– *Fill for each completed hospital stay.*

Doctor/Surgeon		Person No.	Date of entry		
Dollars	Cents		Month	Day	Year

1a. What was the amount of the doctor's and surgeon's bill for this stay?

b. Is the $ for the doctor's and surgeon's bill included in the $ amount you gave me for the hospital bill?

1 ☐ Yes (In a footnote, indicate the actual amount of the hospital bill after deducting the doctor's and surgeon's bills, also indicate any changes in the amounts paid by health insurance or other sources if the entries in Qs. 9 and 10 include payments for expenses other than the hospital bill).

2 ☐ No–*Go to 2*

2a. Did (will) health insurance pay any part of the doctor's and surgeon's bill? ☐ Yes ☐ No–*Go to 3*

	Name of Insurance Plan	Dollars	Cents
b. What is the name of the Insurance Plan?			
c. Did (will) any other health insurance plan pay part of the doctor's and surgeon's bill? ☐ Yes–*Reask b* ☐ No–*Ask d*			
For each Health Insurance Plan named, ask: **d. What was (will be) the amount paid by (Name of plan)?**			

Enter total amount paid by health insurance in line A
Enter any amount paid by Social Security Medicare in line B
If total amount paid is the same or greater than the amount of the bill, ask b.

3a. Who paid (will pay) the (remainder of the) doctor's and surgeon's bill?

b. Did any other person or agency pay any other part of the doctor's and surgeon's bill? ☐ Yes–*Ask c* ☐ No–*Go to d*

c. Who was this? Mark appropriate box and reask b.

d. What was the amount paid by – –?

Source of Payment	Dollars	Cents
A. 1 ☐ Health Insurance–All plans excl. Medicare		
B. 2 ☐ Social Security Medicare		
C. 3 ☐ Self and Family		
D. 4 ☐ Other–*Specify* _____		
Total of above–include amount paid by health insurance →		

Interviewer: After totaling all sources of payment for the doctor's and surgeon's bill, check one of the following boxes:

☐ Total amount paid (to be paid) agrees with amount of doctor's bill–*Go to Q. 11*

☐ Total amount paid (to be paid) does not agree with amount of the doctor's bill–*Resolve difference with respondent*

NOTE: Turn to back cover (p. 12) for additional Doctor's and Surgeon's Bill Supplement.

NOTE: Fill pages 2-11 after asking Q. 27 on the Fosdic Questionnaire. Begin with the Interviewer Check Item below.

		①
INTERVIEWER CHECK ITEM If person is under 17 years, or not in Labor Force (Q. 26 a-d blank) check "Not in Labor Force." If in Labor Force (Q. 26 filled) refer to Question 13 and make appropriate entry.		4 ☐ Not in Labor Force or Under 17 0 ☐ No work-loss days-in LF *Go to next person* ☐ Work-loss days _____ *Go to 4a*
Earlier you said that – – lost – – days from work during the past 2 weeks – (If self-employed, ask b; for other workers, ask a) **4a. Was – – paid any wages by his employer for the days that he lost?**	4a.	1 ☐ Yes–*Ask c* ☐ No–*Ask b*
b. Does – – have any insurance that pays him for the income he lost on these days?	b.	2 ☐ Yes–*Ask c* 3 ☐ No–*Ask d–g*
c. Did he receive his full day's pay for all of these – – days he lost?	c.	1 ☐ Yes–*Ask f–h* 2 ☐ No–*Ask d–h*
d. In total, how much income did – – lose because of the – – days he lost from work?	d.	*Dollars* | *Cents* $ _____
e. Is this before or after taxes?	e.	1 ☐ Before 2 ☐ After
f. How much does – – usually earn per week?	f.	*Dollars* | *Cents* $ _____
g. Is this before or after taxes?	g.	1 ☐ Before 2 ☐ After
Ask if "Yes" in 4a or 4b: **h. Did – – receive this income for these days through a sick leave plan, loss-of-pay insurance, or some other way?**	h.	1 ☐ Sick leave plan 2 ☐ Loss-of-pay insurance 3 ☐ Other - *Specify* _____

FOOTNOTES:

These next questions are about health insurance. We are interested in all kinds of health insurance which pays for MOST KINDS of illness. However, we do not want to include insurance which pays ONLY for accidents.

5a. Is anyone in the family covered by a health insurance plan which pays all or part of a hospital bill?

☐ Yes–*Ask b and c* ☐ No–*Go to 6a*

b. What is the name of the plan? – Record in Table H. I.

c. Is anyone in the family covered by any other health insurance plan which pays all or part of a hospital bill?

☐ Yes–*Reask b and c* ☐ No–*Complete Table H.I. for each plan reported*

6a. (Besides the – – plan you told me about) is anyone in the family covered by a health insurance plan which pays all or part of a surgeon's bill?

☐ Yes–*Ask b and c* ☐ No–*Go to 7a*

b. What is the name of the plan? – Record in Table H.I.

c. Is anyone in the family covered by any other health insurance plan which pays all or part of a surgeon's bill?

☐ Yes–*Reask b and c* ☐ No–*Complete Table H.I. for each plan reported*

7a. (Besides the – – plan you told me about) is anyone in the family covered by a health insurance plan which pays all or part of a doctor's bill for home calls or office visits?

☐ Yes–*Ask b and c* ☐ No–*Go to 8a*

b. What is the name of the plan? –Record in Table H. I.

c. Is anyone in the family covered by any other health insurance which pays all or part of a doctor's bill for home calls or office visits?

☐ Yes–*Reask b and c* ☐ No–*Complete Table H.I. for each plan reported*

8a. (Besides the – – plan you told me about) is anyone in the family covered by a deductible health insurance plan which pays some part of a bill for doctor visits or for hospital or surgical care, after a certain amount has been paid by the family?

☐ Yes–*Ask b and c* ☐ No–*Go to 9a*

b. What is the name of the plan? –Record in Table H. I.

c. Is anyone in the family covered by any other deductible health insurance plan which pays some part of a bill for doctor visits or for hospital or surgical care after a certain amount has been paid by the family?

☐ Yes–*Reask b and c* ☐ No–*Complete Table H.I. for each plan reported*

INTERVIEWER CHECK ITEM

Mark one box for each person →

①

☐ Und. 65–*Go to next person*

☐ 65 or over–*Ask 9a*

9a. Is – – covered by that part of Social Security Medicare which pays for doctor visits; that is the Medicare plan for which he or some agency must pay $3.00 a month?

☐ Yes–*Ask b*

☐ No–*Go to next person*

If person is covered by any insurance plan in Table H.I. ask for EACH plan:

b. Is this the (name of plan) **you told me about before?**

Line No. ____	Line No. ____	Line No. ____
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No

Go to next person

FOOTNOTES

WASH. USE ONLY

	Type of Plan	Number of Plans	Coverage of Head
H			
S			
D			

TABLE H. I.

Line No.	Q. No.	Name of Plan (1)	Does this (name of plan) pay all or part of a hospital bill? (2)	Does this (name of plan) pay all or part of a surgeon's bill? (3)	**Does this plan pay all or part of a doctor's bill for home calls or office visits?** (4)	**Does this plan pay any part of a doctor's bill for home calls or office visits after a certain amount has been paid by the family?** (5)	**Which members of the family are covered by** (name of plan)? Circle column numbers (6)	If 2 or more members of family covered by this plan ask: **Are all of these persons covered by the same policy?** (7)	For each person 65+ covered by this plan ask: **Is this (name of plan) which covers – – a Social Security Medicare plan?** (8)		
A			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
B			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
C			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered 1 2 3 4 5 6	☐ Yes ☐ No– *Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
D			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
E			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
G			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No
H			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes–*Go to 6* ☐ No	☐ Yes ☐ No	Covered: 1 2 3 4 5 6 Not covered: 1 2 3 4 5 6	☐ Yes ☐ No–*Fill separate line for each policy*	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No	Pers. No. ____ ☐ Yes ☐ No

②	③	④	⑤	⑥
☐ Und. 65–*Go to next person* ☐ 65 or over– *Ask 9a*	☐ Und. 65–*Go to next person* ☐ 65 or over– *Ask 9a*	☐ Und. 65–*Go to next person* ☐ 65 or over– *Ask 9a*	☐ Und. 65–*Go to next person* ☐ 65 or over- *Ask 9a*	☐ Und. 65–*Go to next person* ☐ 65 or over– *Ask 9a*
☐ Yes–*Ask b* ☐ No–*Go to next person*	☐ Yes–*Ask b* ☐ No–*Go to next person*	☐ Yes–*Ask b* ☐ No–*Go to next person*	☐ Yes–*Ask b* ☐ No–*Go to next person*	☐ Yes–*Ask b* ☐ No–*Go to next person*
Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No *Go to next person*	Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No *Go to next person*	Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No *Go to next person*	Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No *Go to next person*	Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No | Line No. ____ ☐ Yes ☐ No *Go to next person*

WASH. USE ONLY (repeated for each of ② to ⑥)

	Type of Plan	Number of Plans	Coverage of Head
H			
S			
D			

	Type of Plan	Number of Plans	Coverage of Head
H			
S			
D			

	Type of Plan	Number of Plans	Coverage of Head
H			
S			
D			

	Type of Plan	Number of Plans	Coverage of Head
H			
S			
D			

	Type of Plan	Number of Plans	Coverage of Head
H			
S			
D			

INTERVIEWER CHECK ITEM

Check questions 22a-22d and 23c on pages 4 and 5 of the Fosdic Questionnaire.

Is a Home Care Page required? → ☐ Yes – *Fill Home Care Page(s).*
☐ No – *Go to Q. 10 on Page 10.*

HOME CARE PAGE

Person No. | Control

Earlier in the interview you mentioned that -- needed help of some kind here at home. I am going to read a list of different kinds of personal care some people need in the home. Please tell me if -- needs help in any of the following ways.	2 No	1 Yes	For each "Yes" answer to 1a, Ask: 1b. Who helps --?	Does anyone else help --?
1a. Does -- need help – in walking up stairs or getting from room to room? . . .				☐ No
in dressing or putting on shoes?				☐ No
Does -- need help – with bathing (shaving) or other toilet activities?				☐ No
in eating or having meals served in bed?				☐ No
Does -- need help – with changing bandages?				☐ No
in receiving injections?				☐ No
with other treatments?				
If "Yes," ask: What kinds of treatment? *Specify* _____				☐ No
Does -- need help – in changing bed positions?				☐ No
in exercising or physical therapy?				☐ No
in cutting toenails?				☐ No
Does -- get any OTHER help or care here at home? . . . . . If "Yes," ask: What kinds of other help or care? *Specify* _____				☐ No

IF PERSON IS NOT RECEIVING CARE (All "No's" to question 1a), reconcile differences between answers in Q. 22 or 23 and Q. 1a above or describe the situation in the footnote space below.

2. For what condition(s) does -- receive this help or care? → *Specify condition(s)* _____

3. How long has -- received help or care at home? *Mark one box:*

0 ☐ 1 month or less
1 ☐ Over 1 to 6 months
2 ☐ Over 6 to 12 months
3 ☐ Over 1 to 3 years
4 ☐ Over 3 to 5 years
5 ☐ Over 5 years

4. Because of --'s health, must someone be in the house with him all of the time, part of the time, or only when providing the needed help or care?

1 ☐ All of the time
2 ☐ Part of the time
3 ☐ Only when providing the needed help or care

For each person, other than a nurse, listed in 1b, ask:

5a. Is -- a nurse, a physical therapist, or some other kind of health worker?

If "Nurse" reported in Q. 1b or 5a, ask:

5b. Is the nurse that cares for -- a registered nurse, a practical nurse, or some other kind of nurse?

(Determine the type(s) of person(s) providing the care in question 1 and mark appropriate box in column (1) of Table H.)

FOOTNOTES:

TABLE H

Type of persons providing care (1)		During the past two weeks on about how many days did – – receive help or care from (relative, nurse, etc.)? (2)		About how many hours a day does – – receive help or care from (relative, nurse, etc.)? (3)			Is (relative, nurse, etc.) paid for these services? (4)	
		Days	xx Don't know	Hours	00 Less than 1 hour	xx Don't know	1 Yes	2 No
NON-HEALTH WORKERS	**A.** 8 ☐ Related household members							
	B. 1 ☐ Related persons not in household							
	C. 2 ☐ Friend or neighbor							
	D. 3 ☐ Other *Specify* _____							
HEALTH WORKERS	**E.** 4 ☐ Nurse – Registered							
	F. 5 ☐ Nurse – Practical or other							
	G. 6 ☐ Physical therapist							
	H. 7 ☐ Other *Specify* _____							

INTERVIEWER: Mark the appropriate box before going to Q's 6–8. →

☐ Person 65+ and "Yes" in column (4). *Ask Q's 6, 7, and 8.*

☐ Person 55–64 and "Yes" in column (4). *Ask Q's 7 and 8.*

☐ All "No's" in column (4) or only "A" checked in column (1) of Table H. *Skip to question 8.*

6. Are any of these services paid for by Medicare?

1 ☐ Yes 2 ☐ No x ☐ Don't know

7a. Who pays (the remainder of the bill) for these services?
b. Anyone else?

1 ☐ Self or family
2 ☐ Other relative or friend
3 ☐ Health insurance
4 ☐ Agency or organization (Visiting Nurses Association, etc.)
5 ☐ Welfare
6 ☐ Other – *Specify* _____

8a. During the past 12 months, has – – received any care at home from a nurse?

☐ Yes – *Ask 8b* 000 ☐ No – *Stop*

b. During the past 12 months, ABOUT how many visits did a nurse make to care for – – ?

Number of visits

FOOTNOTES

WASHINGTON USE

		①
These next questions are about motor vehicle accidents, that is, accidents, involving cars, trucks, buses, motorcycles, and so forth. We are interested in all types of motor vehicle accidents even if no one was injured.		
10a. During the past 12 months, has – – been in a motor vehicle accident either as a (driver), passenger or pedestrian?	10a.	☐ Yes – *Ask b* ☐ No – *Go to next person*
b. How many motor vehicle accidents has – – been in during the past 12 months?	b.	_____ Number of accidents
c. On what date(s) did the accident(s) happen?	c.	Month / Day / Year 1. 2. 3.
d. Was – – in any other motor vehicle accident during the past 12 months?	d.	☐ Yes – *Reask c and d* ☐ No – *Go to next person*
Ask for all persons 14 years of age and older: **11a. Has – – driven a motor vehicle during the past 12 months?**	11a.	XV ☐ Under 14 years XX ☐ No ☐ Yes – *Ask 11b* } *Go to next person*
b. How many years has – – been driving?	b.	00 ☐ Less than 1 year _____ Number of years

INTERVIEWER CHECK ITEM

☐ None

Fill a Motor Vehicle Accident Supplement for each motor vehicle accident reported in Q. 10 above.
If no motor vehicle accidents reported – fill the Household Page and end interview.

Number of MVA supplements: _____

FOOTNOTES

HOSPITAL PAGE (Cont'd) **DOCTOR'S AND SURGEON'S BILL SUPPLEMENT**– *Fill for each completed hospital stay.*

Doctor/Surgeon		Person No.	Date of entry		
Dollars	Cents		Month	Day	Year

1a. What was the amount of the doctor's and surgeon's bill for this stay?

b. Is the $ for the doctor's and surgeon's bill included in the $ amount you gave me for the hospital bill?

1 ☐ Yes (In a footnote, indicate the actual amount of the hospital bill after deducting the doctor's and surgeon's bills, also indicate any changes in the amounts paid by health insurance or other sources if the entries in Qs. 9 and 10 include payments for expenses other than the hospital bill).

2 ☐ No–*Go to 2*

2a. Did (will) health insurance pay any part of the doctor's and surgeon's bill? ☐ Yes ☐ No–*Go to 3*

	Name of Insurance Plan	Dollars	Cents
b. What is the name of the Insurance Plan?			
c. Did (will) any other health insurance plan pay part of the doctor's and surgeon's bill? ☐ Yes–*Reask b* ☐ No–*Ask d*			
For each Health Insurance Plan named, ask: d. What was (will be) the amount paid by (Name of plan)?			

Enter total amount paid by health insurance in line A
Enter any amount paid by Social Security Medicare in line B
If total amount paid is the same or greater than the amount of the bill, ask b.

3a. Who paid (will pay) the (remainder of the) doctor's and surgeon's bill?

b. Did any other person or agency pay any other part of the doctor's and surgeon's bill? ☐ Yes–*Ask c* ☐ No–*Go to d*

c. Who was this? Mark appropriate box and reask b.

d. What was the amount paid by – –?

Source of Payment	Dollars	Cents
A. 1 ☐ Health Insurance–All plans excl. Medicare		
B. 2 ☐ Social Security Medicare		
C. 3 ☐ Self and Family		
D. 4 ☐ Other–*Specify* _____		
Total of above–include amount paid by health insurance →		

Interviewer: After totaling all sources of payment for the doctor's and surgeon's bill, check one of the following boxes:

☐ Total amount paid (to be paid) agrees with amount of doctor's bill–*Go to Q. 11*

☐ Total amount paid (to be paid) does not agree with amount of the doctor's bill–*Resolve difference with respondent*

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