

FORM **DFS-3**
(7-1-94)

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 AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

**DISABILITY FOLLOWBACK SURVEY
(NHIS PHASE II)
SUPPLEMENT ON AGING QUESTIONNAIRE**

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RT 01
3-7
8

RT 06
3-4

Part I - CALL RECORD

Mode	Date		Beginning time	Results	Ending time	Comments
	Month	Day				
5	6-7	8-9	10-14		15-19	
T			a.m.		a.m.	
P			p.m.		p.m.	
T			a.m.		a.m.	
P			p.m.		p.m.	
T			a.m.		a.m.	
P			p.m.		p.m.	
T			a.m.		a.m.	
P			p.m.		p.m.	
T			a.m.		a.m.	
P			p.m.		p.m.	

Part II - STATUS

A. Final Status 20-21		B. Mode 22		C. Respondent 64	
Interview 01 <input type="checkbox"/> Complete 02 <input type="checkbox"/> Partial (Explain in Notes) Noninterview 03 <input type="checkbox"/> SP refused 04 <input type="checkbox"/> Proxy refused 05 <input type="checkbox"/> Unable to contact 06 <input type="checkbox"/> Unable to locate 07 <input type="checkbox"/> Deceased 08 <input type="checkbox"/> Institutionalized, no proxy 09 <input type="checkbox"/> Incapable, no proxy 10 <input type="checkbox"/> Moved o/s PSU, unable to phone 11 <input type="checkbox"/> Other noninterview		1 <input type="checkbox"/> Telephone 2 <input type="checkbox"/> Personal visit D. Proxy Name 23-63 E. Field Representative's Name Code 66-68		1 <input type="checkbox"/> Self 2 <input type="checkbox"/> Proxy <input checked="" type="checkbox"/> Reason for proxy 1 <input type="checkbox"/> SP incapable 2 <input type="checkbox"/> SP institutionalized 3 <input type="checkbox"/> SP unavailable 4 <input type="checkbox"/> Other - Specify <input checked="" type="checkbox"/> (Fill II.D) 65	

Part III - NEW ADDRESS

RT 07
3-4

Notes

A. Address (Different from label)					
Number and street 5-29					
City 30-49	State 50-51	ZIP Code 52-60			
B. Telephone (Different from label)					
Area code 61-63	Number 64-70	1 <input type="checkbox"/> None 71 7 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK number			

INITIAL SCREENING

3-4

1. May I please speak with <i>(sample person)</i>?	1 <input type="checkbox"/> Yes (<i>Skip to A below</i>) 2 <input type="checkbox"/> No (<i>Go to 2</i>)	5
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2. Why is <i>(sample person)</i> not available to be interviewed?	1 <input type="checkbox"/> SP deceased (<i>Skip to 6</i>) 2 <input type="checkbox"/> SP moved (<i>Skip to 4</i>) 3 <input type="checkbox"/> SP temporarily absent/unavailable (<i>Go to 3</i>) 4 <input type="checkbox"/> SP incapable } (<i>Skip to 5</i>) 5 <input type="checkbox"/> Other	6
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3. Will <i>(sample person)</i> [return/be available] before <i>(closeout date)</i>?	1 <input type="checkbox"/> Yes (<i>Schedule appointment</i>) 2 <input type="checkbox"/> No } (<i>Go to 4</i>) 9 <input type="checkbox"/> DK	7
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4a. Has <i>(sample person)</i> moved to a new residence or is [he/she] in a health facility, group home, or some other place?	1 <input type="checkbox"/> SP moved (<i>Record new address and telephone no.</i>) 2 <input type="checkbox"/> SP in health facility/group home (<i>Go to 4b</i>) 3 <input type="checkbox"/> SP in jail (<i>Skip to 5</i>) 4 <input type="checkbox"/> SP in prison (<i>END interview - noninterview</i>) 5 <input type="checkbox"/> SP on vacation/visiting/temporarily absent (<i>Skip to 4d</i>)	8
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b. What type of facility or group home is this? Mark (X) first appropriate box.	01 <input type="checkbox"/> Hospital } (<i>Go to 4c</i>) 02 <input type="checkbox"/> Nursing/convalescent home 03 <input type="checkbox"/> Retirement home 04 <input type="checkbox"/> Group home 05 <input type="checkbox"/> Supervised apartment 06 <input type="checkbox"/> Halfway house 07 <input type="checkbox"/> Board and Care home 08 <input type="checkbox"/> Developmental Center 09 <input type="checkbox"/> Other supervised group residence or facility 10 <input type="checkbox"/> Other	9-10
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(Record new address and telephone no.)

c. Refer to age on label.	1 <input type="checkbox"/> Under 69 (<i>Skip to 5</i>) 2 <input type="checkbox"/> 69+ (<i>Go to 4d</i>)	11
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d. Is it possible to interview <i>(sample person)</i> at the [facility/present location]?	1 <input type="checkbox"/> Yes (<i>Record address and telephone no.</i>) 2 <input type="checkbox"/> No (<i>Go to 5</i>)	12
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5. Since I won't be able to interview <i>(sample person)</i>, I need to talk to the person who knows the most about <i>(sample person's)</i> health. Who would that be?	1 <input type="checkbox"/> Respondent (<i>Skip to A below</i>) 2 <input type="checkbox"/> Other person (<i>Record person's name, address, and telephone no.</i>) 3 <input type="checkbox"/> No one } (<i>END interview - noninterview</i>) 9 <input type="checkbox"/> DK/Ref	13
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6. On what date did <i>(sample person)</i> die?	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Month</td> <td style="padding: 2px;">Day</td> <td style="padding: 2px;">Year</td> </tr> <tr> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> </tr> </table> } (<i>Go to 7</i>) 999999 <input type="checkbox"/> DK	Month	Day	Year				14-19
Month	Day	Year						

7. Did <i>(sample person)</i> die at home, in a hospital, in a nursing or convalescent home, or some other place?	1 <input type="checkbox"/> At home 2 <input type="checkbox"/> In hospital 3 <input type="checkbox"/> In nursing/convalescent home } (<i>END interview - noninterview</i>) 4 <input type="checkbox"/> Other place 9 <input type="checkbox"/> DK	20
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A	Begin interview by asking: When we conducted the interview several months ago, we recorded <i>(sample person's)</i> age as <i>(age from label)</i>. Is this still correct?	21
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Notes	1 <input type="checkbox"/> Yes (<i>Skip to Section A on page 4</i>) 2 <input type="checkbox"/> No (<i>Correct age on label, then skip to Section A on page 4</i>)
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INITIAL SCREENING - Continued

NEW ADDRESS (First or only) RT 09 3-4	Second (If appropriate) RT 10 3-4
Name of place (If appropriate) 5-40	Name of place (If appropriate) 5-40
Number and street 41-64	Number and street 41-64
City 65-84 State 85-86 ZIP Code 87-95	City 65-84 State 85-86 ZIP Code 87-95
Telephone	
Area code 96-98 Number 99-105 <input type="checkbox"/> None <input type="checkbox"/> DK 106 <input type="checkbox"/> Refused number	Area code 96-98 Number 99-105 <input type="checkbox"/> None <input type="checkbox"/> DK 106 <input type="checkbox"/> Refused number
PROXY RESPONDENT RT 11 3-4	
Name 5-40	
<input type="checkbox"/> Mark box if same address/phone as SP (Skip to A1 on page 4) 41 Number and street 42-65	
City 66-85 State 86-87 ZIP Code 88-96	
Telephone	
Area code 97-99 Number 100-106 <input type="checkbox"/> None <input type="checkbox"/> DK 107 <input type="checkbox"/> Refused number	

GENERAL INSTRUCTIONS

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Conduct all interviews by personal visit unless the only way to get an interview is by telephone. 2. After appropriate introductions, begin all interviews with A on page 2. 3. If the sample person (or proxy) is not within your normal assignment area, call your office for instructions. 4. Make minor corrections to the sample person's address or phone number on the LABEL. Record new addresses and/or phone numbers above. 5. If a question is refused, enter "REF" in the answer space. If the respondent does not know the answer to a question, mark the "DK" box if there is one, or enter "DK" in the answer space. | <ol style="list-style-type: none"> 6. The following symbols and print types are used throughout the questionnaire to standardize the asking of the questions: <ul style="list-style-type: none"> • Long dash (—) – Insert the appropriate words or names from the list. • Underlined italics in parentheses – Insert the specified words, name, date, etc. • Regular type in parentheses – Either read or do not read the parenthetical, depending on the situation and the context of the question. • Brackets with a slash ([/]) – Choose the appropriate words or phrase for the particular interview. • Bold capitals – Emphasize the word(s) when reading the question. 7. If interviewing a proxy, substitute the sample person's name (or appropriate pronoun) for the word "You" in the questions. |
|--|---|

Notes

Section A – HOUSING AND LONG-TERM CARE SERVICES

ITEM A1	Status of Sample Person (SP).	1 <input type="checkbox"/> Institutionalized (<i>Skip to 6 on page 5</i>) 2 <input type="checkbox"/> All others (<i>Go to 1</i>)	5
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These first questions are about the place you live.		6-7
1. How long have you been living here?	00 <input type="checkbox"/> Less than 1 year _____ Years (Number) 99 <input type="checkbox"/> DK	

2a. Is it NECESSARY to use any steps or stairs to get into this home from the outside?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	8
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b. Counting basements and step down living areas as separate levels, does this home have more than one floor or level?	1 <input type="checkbox"/> Yes (<i>Go to 2c</i>) 2 <input type="checkbox"/> No } (<i>Skip +-</i>) 9 <input type="checkbox"/> DK	9
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c. Does this home have a bathroom, bedroom, and kitchen ALL on the SAME floor or level?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	10
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3. Because of a physical impairment or health problem, do you have any difficulty —		
	Yes No DK	
a. Entering or leaving your home?	a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	11
b. Opening or closing any of the doors in your home?	b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	12
c. Reaching or opening cabinets in your home?	c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	13
d. Using the bathroom in your home?	d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	14

4. Some residences have special features to assist persons who have physical impairments or health problems. Whether you use them or not, does your residence have any of these features?		
	Yes No DK	
a. Widened doorways or hallways?	a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	15
b. Ramps or street level entrances?	b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	17
c. Railings?	c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	19
d. Automatic or easy to open doors?	d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	21
e. Accessible parking or drop-off site?	e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	23
f. Bathroom modifications?	f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	25
g. Kitchen modifications?	g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	27
h. Elevator, chair lift, or stair glide?	h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	29
i. Alerting devices?	i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	31
j. Any other special features?	j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>	33

If all "Yes" in 4, skip to 6 on page 5; otherwise, ask 5 only for those features NOT marked "Yes" in 4.

5. Which special features do you NEED to get around this home, but do not have?		
	Yes No DK	
a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		16
b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		18
c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		20
d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		22
e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		24
f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		26
g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		28
h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		30
i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		32
j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> <input type="checkbox"/>		34

Notes

Section A - HOUSING AND LONG-TERM CARE SERVICES - Continued

ASK OR VERIFY:

35-36

6a. Is this place a — *(Read all categories)*

Mark (X) only one.

- 01 **Single family house or townhouse that is not part of a retirement community, (Skip to 9 on page 6)**
- 02 **Single family house, townhouse, or apartment that is part of a retirement community, (Skip to 7)**
- 03 **Regular apartment, (Skip to 9 on page 6)**
- 04 **Supervised apartment,**
- 05 **Group home,**
- 06 **Halfway house,**
- 07 **Personal care or board and care home,**
- 08 **Developmental center,**
- 09 **Some other type of supervised group residence or facility,**
- 10 **Assisted living facility,**
- 11 **Nursing or convalescent home,**
- 12 **Retirement home,**
- 13 **Center for Independent Living, or**
- 14 **Something else?**
- 99 **DK**

(Go to 6b)

ASK OR VERIFY:

37

b. Does this place primarily or exclusively serve people who are elderly?

- 1 Yes
- 2 No
- 9 DK

**ITEM
A2**

Status of SP.

38

- 1 Institutionalized *(Skip to 10 on page 6)*
- 2 All others *(Go to 7)*

7. Whether you use them or not, does this place routinely provide services such as meals, help with housework or personal care, transportation, or recreation?

39

- 1 Yes *(Go to 8 on page 6)*
 - 2 No
 - 9 DK
- } *(Skip to 9 on page 6)*

Notes

Section A – HOUSING AND LONG-TERM CARE SERVICES – Continued

8. Whether you use them or not, does this place routinely provide —	Yes	No	DK	
a. Group meals for residents?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	40
b. Housekeeping or maid service?	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	41
c. Nursing or medical care?	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	42
d. Supervision of residents who give themselves their own medication?	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	43
e. Help with bathing, eating, or dressing?	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	44
f. Help with walking or getting about?	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	45
g. Help with shopping?	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	46
h. Planned social activities or trips?	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	47
i. Educational or training programs?	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	48
j. Help with laundry?	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	49
k. Help with money management?	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	50
l. Transportation?	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	51
m. Protective oversight?	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	52
9. Are you planning a move in order to receive any (additional) personal help, assistance or services?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			53
Mark "Yes" if SP is currently living in a nursing home; otherwise ask: 10a. Have you EVER been a resident or patient in a nursing home?	1 <input type="checkbox"/> Yes (Go to 10b) 2 <input type="checkbox"/> No } (Skip to 12 on page 7) 9 <input type="checkbox"/> DK }			54
b. How many DIFFERENT TIMES have you been a resident or patient in a nursing home (including the current time)?	_____ Times (Number) 99 <input type="checkbox"/> DK			55-56
c. On what date were you admitted (the FIRST time)? If date not known, ask: Was it within the past 12 months?	_____/19_____ Month Year 0001 <input type="checkbox"/> In past 12 months 0002 <input type="checkbox"/> Not in past 12 months 9999 <input type="checkbox"/> DK			57-60
Mark box if "Now in nursing home"; otherwise ask: d. On what date were you discharged (the LAST time)? If date not known, ask: Was it within the past 12 months?	0000 <input type="checkbox"/> Now in nursing home _____/19_____ Month Year 0001 <input type="checkbox"/> In past 12 months 0002 <input type="checkbox"/> Not in past 12 months 9999 <input type="checkbox"/> DK			61-64
e. How long [were you/have you been] in the nursing home (the LAST time/THIS time)?	00 <input type="checkbox"/> Less than 1 month _____ Months (Number) 99 <input type="checkbox"/> DK			65-66
Ask if date in 10d is within the past 12 months, including "Now in". If not within the past 12 months, skip to 12 on page 7. f. How many weeks in the past 12 months [were you/have you been] in a nursing home?	00 <input type="checkbox"/> Less than 1 week _____ Weeks (Number) 99 <input type="checkbox"/> DK			67-68

Section A - HOUSING AND LONG-TERM CARE SERVICES - Continued

HAND CARD A1. Read categories if telephone interview.

11a. Who paid or will pay for your nursing home stays in the past 12 months?

(Anyone else?)

Mark (X) all that apply.

- 01 Self or family in household
- 02 Family NOT in household
- 03 Private health insurance
- 04 Medicare
- 05 Medicaid
- 06 Rehabilitation program
- 07 Employer
- 08 School system
- 09 VA program
- 10 Other military
- 11 Other private source
- 12 Other public source
- 13 No one/Free
- 99 DK

69-70
71-72
73-74
75-76
77-78
79-80
81-82
83-84
85-86
87-88
89-90
91-92
93-94
95-96

Ask if more than one source in 11a. If only one source in 11a, transcribe the number of the box marked without asking.

b. Who paid or will pay the most for your nursing home stays in the past 12 months?

Record number of the main source.

Paid most
(Number)

99 DK

97-98

Ask only if box 01 marked in 11a; otherwise, skip to 12.

c. During the past 12 months, about how much did you or your family pay for your nursing home stays? Do not count any money that has been or will be reimbursed by insurance or any other source.

000000 None

\$ _____ . 00

999999 DK

99-104

If "Now in nursing home" marked in 10d, skip to Section D on page 10; otherwise, ask:

12. Are you currently on a waiting list to go into a nursing home?

- 1 Yes
- 2 No
- 9 DK

105

Notes

Section B - TRANSPORTATION

3-4

5

ITEM B1

Status of SP.

- 1 Institutionalized (Skip to Section D on page 10)
- 2 All others (Go to 1)

These next questions are about getting around outside your home.

6

1. How frequently do you drive a car or other motor vehicle? Would you say — (Read all categories)
Mark (X) only one.

- 1 Everyday or almost everyday,
 - 2 Occasionally,
 - 3 Seldom, or
 - 4 Never? (Go to 2)
 - 9 DK (Skip to 3)
- } (Skip to 3)

2. Is this because of an impairment or health problem?

7

- 1 Yes
- 2 No
- 9 DK

3a. During the past 12 months, have you used local public transportation, such as a regular bus line, rapid transit, subway, or street car?
Mark (X) only one.

8

- 0 No public system available (Skip to Section C on page 9)
- 1 Yes (Skip to 3c)
- 2 No (Go to 3b)
- 9 DK (Go to 3b)

b. Does an impairment or health problem prevent or limit your use of the public transportation service?
Mark (X) only one.

9

- 0 No public system available
 - 1 Yes
 - 2 No
 - 9 DK
- } (Skip to Section C on page 9)

c. During the past 12 months, how often did you use the local public transportation service? Would you say — (Read all categories)
Mark (X) only one.

10

- 1 Everyday or almost everyday,
- 2 Occasionally, or
- 3 Seldom?
- 9 DK

d. Because of an impairment or health problem, during the past 12 months, did you have any difficulty using the local public transportation service?

11

- 1 Yes
- 2 No
- 9 DK

Notes

Section C – SOCIAL ACTIVITY

Reminder – If SP is institutionalized, skip to Section D on page 10.

These next questions are about various activities you may have participated in.

1. DURING THE PAST 2 WEEKS, did you —

Yes No DK

- | | | | | | |
|---|-----------|----------------------------|----------------------------|----------------------------|----|
| a. Get together socially with friends or neighbors? | a. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 12 |
| b. Talk with friends or neighbors on the telephone? | b. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 13 |
| c. Get together with ANY relatives not including those living with you? | c. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 14 |
| d. Talk with ANY relatives on the telephone not including those living with you? | d. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 15 |
| e. Go to church, temple, or another place of worship for services or other activities? | e. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 16 |
| f. Go to a show or movie, sports event, club meeting, class, or other group event? | f. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 17 |
| g. Go out to eat at a restaurant? | g. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 18 |

2. How many days in the past two weeks did you leave your home for any reason?

- 14 Every day
00 None

_____ Days
(Number)

- 99 DK

19-20

If proxy respondent, skip to Section D on page 10; otherwise ask:

3. Regarding your present social activities, do you feel that you are doing about enough, too much, or would you like to be doing more?

Mark (X) only one.

- 1 About enough
2 Too much
3 Would like to be doing more
9 DK

21

Notes

Section D - WORK HISTORY/EMPLOYMENT

These next questions are about working for pay or profit, and about unpaid volunteer work.

22

1. Have you EVER worked at a job or business?

- 1 Yes (Go to 2)
 2 No } (Skip to 7)
 9 DK

2. Do you NOW work at a job or business?

23

- 1 Yes (Go to 3)
 2 No } (Skip to 4)
 9 DK

3. About how many hours a week do you usually work at your current job?

24-25

(Note: If more than one job, include all jobs.)

- ____ Hours per week } (Skip to 5)
 (Number)
 99 DK

4. In what year did you stop working at your last job?

26-27

- 19 ____ Year
 99 DK

5a. Have you retired from a job or business?

28

- 1 Yes (Go to 5b)
 2 No } (Skip to 7)
 9 DK

b. How old were you when you retired the last time?

29-30

- ____ Age
 99 DK

6. Did you retire because of an ongoing health problem, impairment, or disability?

31

- 1 Yes
 2 No
 9 DK

7. DURING THE PAST 12 MONTHS, were you involved in unpaid volunteer work such as teaching or coaching, office work, or providing care?

32

- 1 Yes (Go to 8)
 2 No } (Skip to Section E on page 11)
 9 DK

8. How many days did you do volunteer work in the past 12 months?

33-36

- ____ } 1 Per week
 (Days) } 2 Per month
 } 3 Per year
 9999 DK

Notes

Section E - ASSISTIVE DEVICES AND TECHNOLOGIES

The next questions are about medical devices and implants.

Ask all of 1a-o before going to 2.

Ask for each "Yes" in 1.

1. During the past 12 months, did you use any of the following medical devices or supplies?

2. Did you use (device) in the past two weeks?

	Yes	No	DK		Yes	No	DK	
a. A tracheotomy tube?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	5	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	6
b. A respirator?	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	7	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	8
c. An ostomy bag?	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	9	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	10
d. Catheterization equipment?	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	11	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	12
e. A glucose monitor?	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	13	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	14
f. Diabetic equipment or supplies?	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	15	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	16
g. An inhaler?	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	17	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	18
h. A nebulizer?	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	19	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	20
i. A hearing aid?	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	21	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	22
j. Crutches?	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	23	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	24
k. A cane?	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	25	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	26
l. A walker?	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	27	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	28
m. A wheelchair?	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	29	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	30
n. A scooter?	n. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	31	n. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	32
o. A feeding tube?	o. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	33	o. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	34

3. Do you now have any of the following implants?

	Yes	No	DK	
a. Any shunt that drains away fluid?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	35
b. An artificial joint?	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	36
c. Implanted lens?	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	37
d. Implanted pin, screw, nail, wire, rod, or plate?	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	38
e. An artificial heart valve?	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	39
f. A pacemaker?	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	40
g. Silicone implant?	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	41
h. Infusion pump?	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	42
i. Implanted catheter?	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	43
j. An organ implant?	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	44
k. A cochlear (kōk'ē-ḏr) implant?	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	45

Notes

Section F – HEALTH INSURANCE

<p>The next questions are about health insurance coverage.</p> <p>There are several government programs that provide medical care or help pay medical bills.</p> <p>People covered by Medicare have a card that looks like this.</p> <p><i>SHOW MEDICARE CARD.</i></p>		46
<p>1a. In (month), were you covered by Medicare?</p>	<p>1 <input type="checkbox"/> Yes (Go to 1b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 2)</p>	
<p>b. How long have you been covered by Medicare?</p> <p><i>Read categories if necessary.</i></p> <p><i>Mark (X) only one.</i></p>	<p>1 <input type="checkbox"/> Less than 6 months 2 <input type="checkbox"/> 6 months, but less than 1 year 3 <input type="checkbox"/> 1 year, but less than 2 years 4 <input type="checkbox"/> 2 years or more 9 <input type="checkbox"/> DK</p>	47
<p>There is a program called MEDICAID that pays for health care for persons in need. In this state, it is also called (state name).</p>		48
<p>2a. In (month), were you covered by MEDICAID or (state name)?</p>	<p>1 <input type="checkbox"/> Yes (Go to 2b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 3)</p>	
<p>b. How long have you had MEDICAID or (state name) coverage?</p> <p><i>Read categories if necessary.</i></p> <p><i>Mark (X) only one.</i></p>	<p>1 <input type="checkbox"/> Less than 6 months 2 <input type="checkbox"/> 6 months, but less than 1 year 3 <input type="checkbox"/> 1 year, but less than 2 years 4 <input type="checkbox"/> 2 years, but less than 5 years 5 <input type="checkbox"/> 5 years or more 6 <input type="checkbox"/> On and off for less than 2 years 7 <input type="checkbox"/> On and off for 2 years, but less than 5 years 8 <input type="checkbox"/> On and off for 5 years or more 9 <input type="checkbox"/> DK</p>	49
<p>3. In (month), were you covered by any OTHER public assistance program (other than Medicaid) that pays for health care? Do NOT include use of public or free clinics if that is your ONLY source of care.</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	50
<p>4a. In (month), were you covered by military health care, including armed forces retirement benefits, the VA (Department of Veterans' Affairs), CHAMPUS, or CHAMP-VA?</p>	<p>1 <input type="checkbox"/> Yes (Go to 4b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to 5)</p>	51
<p>b. Was this CHAMPUS, or CHAMP-VA?</p> <p><i>Read if necessary: CHAMPUS is a program of medical care for dependents of active duty or retired military personnel. CHAMP-VA is medical insurance for dependents or survivors of disabled veterans.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	52
<p>c. In (month), were you covered by any other military health care, including armed forces retirement benefits, or the VA (Department of Veterans' Affairs)?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	53
<p>5. In (month), were you covered by the Indian Health Service?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	54
<p>6a. (Not counting the government health programs we just mentioned), in (month), were you covered by a private health insurance plan?</p> <p><i>Read if necessary: Besides government programs, people also get health insurance through their jobs or union, through other private groups, or directly from an insurance company. A variety of types of plans are available, including Health Maintenance Organizations or HMOs.</i></p>	<p>1 <input type="checkbox"/> Yes (Go to 6b) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Skip to Section G on page 13)</p>	55
<p>b. Was any of this private health insurance obtained originally through the workplace, that is through a present or former employer or union?</p> <p><i>Mark (X) only one</i></p>	<p>1 <input type="checkbox"/> Employer 2 <input type="checkbox"/> Union 3 <input type="checkbox"/> Through workplace, DK which 4 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	56

Section G – ASSISTANCE WITH KEY ACTIVITIES

READ TO RESPONDENT: The next questions are about how well you are able to do certain activities. Please tell me if you have ANY difficulty when you do the following.

Ask 1a-j before asking 2 and 3.		Ask 2 and 3 for each "Yes" in 1a-j.	
1. By yourself and not using aids, do you have any difficulty —		2. How much difficulty do you have (activity), some, a lot, or are you unable to do it?	3. For how long have you [had some difficulty/had a lot of difficulty/been unable to] (activity)?
a. Walking for a quarter of a mile, (that is about 2 or 3 blocks)?	<input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 6 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 7-8 <input type="checkbox"/> DK _____ Number of years
b. Walking up 10 steps without resting?	<input type="checkbox"/> Yes 9 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 10 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 11-12 <input type="checkbox"/> DK _____ Number of years
c. Standing or being on your feet for about 2 hours?	<input type="checkbox"/> Yes 13 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 14 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 15-16 <input type="checkbox"/> DK _____ Number of years
d. Sitting for about 2 hours?	<input type="checkbox"/> Yes 17 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 18 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 19-20 <input type="checkbox"/> DK _____ Number of years
By yourself and not using aids, do you have any difficulty —			
e. Stooping, crouching, or kneeling?	<input type="checkbox"/> Yes 21 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 22 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 23-24 <input type="checkbox"/> DK _____ Number of years
f. Reaching up over your head?	<input type="checkbox"/> Yes 25 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 26 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 27-28 <input type="checkbox"/> DK _____ Number of years
g. Reaching out (as if to shake someone's hand)?	<input type="checkbox"/> Yes 29 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 30 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 31-32 <input type="checkbox"/> DK _____ Number of years
h. Using your fingers to grasp or handle?	<input type="checkbox"/> Yes 33 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 34 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 35-36 <input type="checkbox"/> DK _____ Number of years
By yourself and not using aids, do you have any difficulty —			
i. Lifting or carrying something as heavy as 25 pounds, (such as two full bags of groceries)?	<input type="checkbox"/> Yes (Go to j) 37 <input type="checkbox"/> No (Skip to 2) <input type="checkbox"/> NA/DK (Go to j)	<input type="checkbox"/> Some 38 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 39-40 <input type="checkbox"/> DK _____ Number of years
j. Lifting or carrying something as heavy as 10 pounds?	<input type="checkbox"/> Yes 41 <input type="checkbox"/> No <input type="checkbox"/> NA/DK	<input type="checkbox"/> Some 42 <input type="checkbox"/> A lot <input type="checkbox"/> Unable <input type="checkbox"/> DK	<input type="checkbox"/> Less than 1 year 43-44 <input type="checkbox"/> DK _____ Number of years

Notes

Section G – ASSISTANCE WITH KEY ACTIVITIES – Continued

READ TO RESPONDENT: These questions are about some other activities and how well you are able to do them by yourself and without using special equipment.

Ask questions 4A–G before continuing to Item G1. 4. Because of a health or physical problem, do you have ANY difficulty — Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem? If "Yes", mark box 1; if "No" mark box 3.	(A) RT 16 3-4	(B) RT 17 3-4	(C) RT 18 3-4
	Bathing or showering?	Dressing?	Eating?
4.	4. <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK	4. <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK	4. <input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input type="checkbox"/> DK

	(A)	(B)	(C)
	Bathing or showering	Dressing	Eating
ITEM G1	G1 Refer to question 4. 6 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 6 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 6 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)
5. By yourself and without using special equipment, how much difficulty do you have (activity), some, a lot, or are you unable to do it?	5. <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (G1 for next activity) <input type="checkbox"/> DK (Go to 6) 7	5. <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (G1 for next activity) <input type="checkbox"/> DK (Go to 6) 7	5. <input type="checkbox"/> Some } (Go to 6) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (G1 for next activity) <input type="checkbox"/> DK (Go to 6) 7
6. When you DO NOT HAVE HELP OR USE SPECIAL EQUIPMENT, is (activity) by yourself — (1) Very tiring? (2) Does (activity) take a long time? (3) Is it very painful?	6. <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) 8 (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 9 (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 10 (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 11 (Go to G1 for next activity)	6. <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) 8 (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 9 (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 10 (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 11 (Go to G1 for next activity)	6. <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) 8 (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 9 (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 10 (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 11 (Go to G1 for next activity)

	(A)	(B)	(C)
	Bathing or showering	Dressing	Eating
ITEM G2	G2 Refer to question 4. 12 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 12 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 12 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)
7a. Do you use any special equipment or aids in (activity)?	7a. <input type="checkbox"/> Yes (Go to 7b) 13 <input type="checkbox"/> No (Go to G2 for next activity)	7a. <input type="checkbox"/> Yes (Go to 7b) 13 <input type="checkbox"/> No (Go to G2 for next activity)	7a. <input type="checkbox"/> Yes (Go to 7b) 13 <input type="checkbox"/> No (Go to G2 for next activity)
b. What special equipment or aids do you use? Anything else? Mark (X) all that apply.	b. <input type="checkbox"/> Stool, seat or chair 14 <input type="checkbox"/> Handbar or rail 15 <input type="checkbox"/> Other 16 <input type="checkbox"/> DK 17	b. <input type="checkbox"/> Special clothes 14 <input type="checkbox"/> Special fasteners 15 <input type="checkbox"/> Cord, string, zipper pull 16 <input type="checkbox"/> Orthopedic shoes 17 <input type="checkbox"/> Other 18 <input type="checkbox"/> DK 19	b. <input type="checkbox"/> Oversized eating equipment 14 <input type="checkbox"/> Bed or lap tray 15 <input type="checkbox"/> Covered cup/modified bowl 16 <input type="checkbox"/> Other 17 <input type="checkbox"/> DK 18
c. When you USE SPECIAL EQUIPMENT AND DO NOT HAVE HELP, is (activity) — (1) Very tiring? (2) Does (activity) take a long time? (3) Is it very painful?	c. <input type="checkbox"/> Never do without help (Go to G2 for next activity) 18 (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 19 (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 20 (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 21 (Go to G2 for next activity)	c. <input type="checkbox"/> Never do without help (Go to G2 for next activity) 20 (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 21 (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 22 (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 23 (Go to G2 for next activity)	c. <input type="checkbox"/> Never do without help (Go to G2 for next activity) 19 (1) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 20 (2) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 21 (3) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK 22 (Go to G2 for next activity)

Section G – ASSISTANCE WITH KEY ACTIVITIES – Continued

(D) RT 19 3-4 Getting in and out of bed or chairs?	(E) RT 20 3-4 Walking?	(F) RT 21 3-4 Getting outside?	(G) RT 22 3-4 Using the toilet, including getting to the toilet?
4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK	4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK	4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK	4. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason 9 <input type="checkbox"/> DK

(D) Getting in and out of bed or chairs	(E) Walking	(F) Getting outside	(G) Using the toilet, including getting to the toilet
G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Go to G1 for next activity)	G1 Refer to question 4. 1 <input type="checkbox"/> "Yes" marked (Go to 5) 2 <input type="checkbox"/> All other (Skip to G2 for activity (A))
5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G1 for next activity) 9 <input type="checkbox"/> DK (Go to 6)	5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G1 for next activity) 9 <input type="checkbox"/> DK (Go to 6)	5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G1 for next activity) 9 <input type="checkbox"/> DK (Go to 6)	5. 1 <input type="checkbox"/> Some } (Go to 6) 2 <input type="checkbox"/> A lot } 3 <input type="checkbox"/> Unable (Go to G2 for activity (A)) 9 <input type="checkbox"/> DK (Go to 6)
6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G1 for next activity)	6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G1 for next activity)	6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G1 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G1 for next activity)	6. 0 <input type="checkbox"/> Never do without help or special equipment (Go to G2 for activity (A)) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for activity (A))

(D) Getting in and out of bed or chairs	(E) Walking	(F) Getting outside	(G) Using the toilet, including getting to the toilet
G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Go to G2 for next activity) 2 <input type="checkbox"/> All other (Go to 7)	G2 Refer to question 4. 1 <input type="checkbox"/> Box 3 marked (Skip to G3 on page 16) 2 <input type="checkbox"/> All other (Go to 7)
7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Go to G2 for next activity)	7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Go to G2 for next activity)	7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Go to G2 for next activity)	7a. 1 <input type="checkbox"/> Yes (Go to 7b) 2 <input type="checkbox"/> No (Skip to G3 on page 16)
b. 1 <input type="checkbox"/> Cane or walking stick 2 <input type="checkbox"/> Walker 3 <input type="checkbox"/> Extra/special cushions 4 <input type="checkbox"/> Special "raising seat" chair/lift chair 5 <input type="checkbox"/> Hospital bed 6 <input type="checkbox"/> Trapeze/sling 7 <input type="checkbox"/> Ramp 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> DK	b. 01 <input type="checkbox"/> Cane or walking stick 02 <input type="checkbox"/> Walker 03 <input type="checkbox"/> Crutch or crutches 04 <input type="checkbox"/> Wheelchair 05 <input type="checkbox"/> Artificial leg 06 <input type="checkbox"/> Brace 07 <input type="checkbox"/> Guide dog 08 <input type="checkbox"/> Oxygen/special breathing equipment 09 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	b. 01 <input type="checkbox"/> Cane or walking stick 02 <input type="checkbox"/> Walker 03 <input type="checkbox"/> Crutch or crutches 04 <input type="checkbox"/> Wheelchair 05 <input type="checkbox"/> Artificial leg 06 <input type="checkbox"/> Brace 07 <input type="checkbox"/> Guide dog 08 <input type="checkbox"/> Oxygen/special breathing equipment 09 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK	b. 01 <input type="checkbox"/> Cane or walking stick 02 <input type="checkbox"/> Walker 03 <input type="checkbox"/> Crutch or crutches 04 <input type="checkbox"/> Wheelchair 05 <input type="checkbox"/> Artificial leg 06 <input type="checkbox"/> Brace 07 <input type="checkbox"/> Guide dog 08 <input type="checkbox"/> Bed pan 09 <input type="checkbox"/> Raised toilet seat 10 <input type="checkbox"/> Special toilet/ portable toilet 11 <input type="checkbox"/> Hand holds/rails near toilet 12 <input type="checkbox"/> Other 99 <input type="checkbox"/> DK
c. 0 <input type="checkbox"/> Never do without help (Go to G2 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for next activity)	c. 0 <input type="checkbox"/> Never do without help (Go to G2 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for next activity)	c. 0 <input type="checkbox"/> Never do without help (Go to G2 for next activity) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G2 for next activity)	c. 0 <input type="checkbox"/> Never do without help (Go to G3 on page 16) (1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G3 on page 16)

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(A) RT 16 Bathing or showering	(B) RT 17 Dressing	(C) RT 18 Eating
ITEM G3	G3 <i>Refer to question 4 on page 14.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity). 2 <input type="checkbox"/> All other (Go to 8)	G3 <i>Refer to question 4 on page 14.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity). 2 <input type="checkbox"/> All other (Go to 8)	G3 <i>Refer to question 4 on page 14.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity). 2 <input type="checkbox"/> All other (Go to 8)
8a. Do you receive help from another person in (activity)?	8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK
b. Is this hands-on help?	b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK
c. When you HAVE HANDS-ON HELP FROM ANOTHER PERSON, is (activity) —	c. 0 <input type="checkbox"/> Never does activity (Skip to 8e)	c. 0 <input type="checkbox"/> Never does activity (Skip to 8e)	c. 0 <input type="checkbox"/> Never does activity (Skip to 8e)
(1) Very tiring?	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Does (activity) take a long time?	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(3) Is it very painful?	(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
d. How often do you have hands-on help with (activity)? Would you say always, sometimes, or rarely?	d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
e. Do you need (more) hands-on help with (activity)?	e. 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	e. 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	e. 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

	(A) RT 16 Bathing or showering	(B) RT 17 Dressing	(C) RT 18 Eating
ITEM G4	G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)
9a. Do you have someone who supervises you or stays nearby when you are (activity)?	9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK
b. Does this person provide —	b.	b.	b.
(1) Supervisory help, such as making sure the activity is performed correctly when you are (activity)?	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Standby help, such as observing to see if any help is needed when you are (activity)?	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
10. How often do you have supervision or standby help when you are (activity)? Would you say always, sometimes, or rarely?	10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
11. Do you need (more) supervision or standby help with (activity)?	11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

(D) Getting in and out of bed or chairs	RT 19	(E) Walking	RT 20	(F) Getting outside	RT 21	(G) Using the toilet, including getting to the toilet	RT 22
G3 <i>Refer to question 4 on page 15.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	27	G3 <i>Refer to question 4 on page 15.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	38	G3 <i>Refer to question 4 on page 15.</i> 1 <input type="checkbox"/> Box 3 marked (Go to G3 for next activity) 2 <input type="checkbox"/> All other (Go to 8)	38	G3 <i>Refer to question 4 on page 15.</i> 1 <input type="checkbox"/> Box 3 marked (Skip to G4 for activity (A)) 2 <input type="checkbox"/> All other (Go to 8)	44
8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	28	8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	39	8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	39	8a. 1 <input type="checkbox"/> Yes (Go to 8b) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	45
b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	29	b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	40	b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	40	b. 1 <input type="checkbox"/> Yes (Go to 8c) 2 <input type="checkbox"/> No } (Skip to 8e) 9 <input type="checkbox"/> DK	46
c. 0 <input type="checkbox"/> Never does activity (Skip to 8e)	30	c. 0 <input type="checkbox"/> Never does activity (Go to 8e)	41	c. 0 <input type="checkbox"/> Never does activity (Skip to 8e)	41	c. 0 <input type="checkbox"/> Never does activity (Skip to 8e)	47
(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	31	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	42	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	42	(1) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	48
(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	32	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	43	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	43	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	49
(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	33	(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	44	(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	44	(3) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	50
d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	34	d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	45	d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	45	d. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	51
e. 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	35	e. 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	46	e. 1 <input type="checkbox"/> Yes } (Go to G3 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	46	e. 1 <input type="checkbox"/> Yes } (Go to G4 for activity (A)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	52

(D) Getting in and out of bed or chairs	(E) Walking	(F) Getting outside	(G) Using the toilet, including getting to the toilet
G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	36	G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	47
G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	47	G4 <i>Refer to G3 and 8b above.</i> 1 <input type="checkbox"/> Box 1 marked in G3 (Go to G4 for next activity) 2 <input type="checkbox"/> "Yes" in 8b (Go to G4 for next activity) 3 <input type="checkbox"/> All other (Go to 9)	53
9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	37	9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	48
9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	48	9a. 1 <input type="checkbox"/> Yes (Go to 9b) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK	54
b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	38	b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	49
b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	49	b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	55
(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	50
(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	50	(2) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	56
10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	40	10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	51
10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	51	10. 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	57
11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	41	11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	52
11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	52	11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	58
11. 1 <input type="checkbox"/> Yes } (Go to G4 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	58	11. 1 <input type="checkbox"/> Yes } (Go to G5 on page 18) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK	58

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(A) RT 16 Bathing or showering	(B) RT 17 Dressing	(C) RT 18 Eating
ITEM G5	<p style="text-align:right; margin-right: 20px;">Refer to 8a, 8e, 9a and 11 on page 16. 37</p> <p>G5</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to G5 for activity (B))</p>	<p style="text-align:right; margin-right: 20px;">Refer to 8a, 8e, 9a and 11 on page 16. 39</p> <p>G5</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to G5 for activity (C))</p>	<p style="text-align:right; margin-right: 20px;">Refer to 8a, 8e, 9a and 11 on page 16. 38</p> <p>G5</p> <p>1 <input type="checkbox"/> Any "Yes" (Go to 12)</p> <p>2 <input type="checkbox"/> All other (Go to G5 for activity (D))</p>
	<p>12a. How often do you have a complete bath? This could be a tub bath, shower, sink bath or bed bath. Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, 38</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p>	<p>12a. Do you get dressed for the day — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, (Skip to 13) 40</p> <p>2 <input type="checkbox"/> 2-3 times per week, } (Go to 12b)</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Do you stay in night clothes?</p> <p>9 <input type="checkbox"/> DK</p>	<p>12a. During the past month, were there times you were unable to eat when you were hungry because no one was available to help you eat?</p> <p>1 <input type="checkbox"/> Yes 39</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>
	<p>b. How often do you have a partial bath? Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, 39</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p>	<p>b. How often do you change your night clothes? Would you say — (Read categories)</p> <p>1 <input type="checkbox"/> Everyday, 41</p> <p>2 <input type="checkbox"/> 2-3 times per week,</p> <p>3 <input type="checkbox"/> Once a week, or</p> <p>4 <input type="checkbox"/> Less than once a week?</p> <p>9 <input type="checkbox"/> DK</p>	<p>b. During the past month, have you —</p> <p>(1) Lost any weight because you were on a diet?</p> <p>1 <input type="checkbox"/> Yes 40</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>
	<p>13a. During the past month, did you experience discomfort because you were not able to bathe as often as you would have liked?</p> <p><i>If necessary: That can be either physical or emotional discomfort.</i></p> <p>1 <input type="checkbox"/> Yes 40</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>	<p>13. During the past month, did you experience discomfort because you were not able to change your clothes as often as you would have liked because you did not have help?</p> <p>1 <input type="checkbox"/> Yes } (Go to G5 for activity (C)) 42</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>	<p>(2) Lost weight even though you were not on a diet?</p> <p>1 <input type="checkbox"/> Yes 41</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>
	<p>b. During the past month, did you experience a burn or scald caused by bathing with water that was too hot?</p> <p>1 <input type="checkbox"/> Yes } (Go to G5 for activity (B)) 41</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p>		<p>(3) Been dehydrated, that is not had enough liquid in your diet?</p> <p>1 <input type="checkbox"/> Yes } (Go to G5 for activity (D)) 42</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <p><i>If necessary: If you were dehydrated, you might have been thirsty or lost body fluids.</i></p>

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

(D) RT 19 Getting in and out of bed or chairs		(E) RT 20 Walking		(G) RT 22 Using the toilet, including getting to the toilet	
G5	Refer to 8a, 8e, 9a and 11 on page 17. 42 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (E))	G5	Refer to 8a, 8e, 9a and 11 on page 17. 53 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Go to G5 for activity (G))	G5	Refer to 8a, 8e, 9a and 11 on page 17. 59 1 <input type="checkbox"/> Any "Yes" (Go to 12) 2 <input type="checkbox"/> All other (Skip to G6 on page 20)
12a.	Because of a health or physical problem, do you usually stay in bed all or most of the time? 1 <input type="checkbox"/> Yes (Skip to G5 for activity (E)) 43 2 <input type="checkbox"/> No } (Go to 12b) 9 <input type="checkbox"/> DK }	12a.	How often do you move around your [house/apartment/room]? Would you say — (Read categories) 1 <input type="checkbox"/> Whenever you want, 54 2 <input type="checkbox"/> Often enough to stretch and have a change of scenery now and then, 3 <input type="checkbox"/> Often enough to take care of toileting needs but not much more than that, or 4 <input type="checkbox"/> Not often enough even to use the bathroom? 9 <input type="checkbox"/> DK (Go to G5 for activity (G))	12a.	During the past month, did you experience discomfort because you did not have help getting to the bathroom or changing soiled clothing as often as you needed to? If necessary: That can be either physical or emotional discomfort. 1 <input type="checkbox"/> Yes 60 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
b.	Because of a health or physical problem, do you usually stay in a chair all or most of the time? 1 <input type="checkbox"/> Yes 44 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			b.	During the past month, did you wet or soil yourself because you did not have help getting to the bathroom, using a bed pan or using a commode? 1 <input type="checkbox"/> Yes (Go to 12c) 61 2 <input type="checkbox"/> No } (Skip to 12d) 9 <input type="checkbox"/> DK }
c.	How often do you get out of bed? Would you say — (Read categories) 1 <input type="checkbox"/> Everyday, 45 2 <input type="checkbox"/> 2-3 times per week, 3 <input type="checkbox"/> Once a week, or 4 <input type="checkbox"/> Less than once a week? 9 <input type="checkbox"/> DK (Go to G5 for activity (E))			c.	During the past month, did you experience skin problems such as a rash or irritation because of this? 1 <input type="checkbox"/> Yes 62 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
				d.	During the past month, did you use a commode or bed pan because no help was available? 1 <input type="checkbox"/> Yes 63 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK (Go to G6 on page 20)

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

**ITEM
G6**

Refer to question 4 for activities A-G on pages 14 and 15. Indicate the activities marked "Yes".
Insert these marked activities when asking 14.

- A. Bathing or showering
- B. Dressing
- C. Eating
- D. Getting in and out of bed or chairs
- E. Walking
- F. Getting outside
- G. Using the toilet, including getting to the toilet
- No activities marked (Skip to 15)

Insert activities marked in G6.

14a. What (other) condition causes the trouble in (activities)?

Record conditions and ask 14b.

Ask if operation:

For what condition did you have the operation?

Record up to 5 conditions.

- 00 No condition (Skip to 15)
- 01 Old age (Go to 14c)

5-6

7-8

(a) _____ 9-10

(b) _____ 11-12

(c) _____ 13-14

(d) _____ 15-16

(e) _____ 17-18

b. Besides (condition), is there any other condition which causes this trouble in (activities)?

- 1 Yes (Reask 14a and 14b)
- 2 No } (Go to 15)
- 9 DK }

19

c. Is this trouble in (activities) caused by any specific condition?

- 1 Yes (Reask 14a and 14b)
- 2 No } (Go to 15)
- 9 DK }

20

15a. Do you have difficulty controlling your bowels?

- 1 Yes (Go to 15b)
- 2 No } (Skip to 15c)
- 9 DK }

21

b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week?

Mark (X) only one.

- 1 Daily
- 2 Several times a week
- 3 Once a week
- 4 Less than once a week
- 9 DK

22

c. Do you have a colostomy or a device to help control bowel movements?

- 1 Yes (Go to 15d)
- 2 No } (Skip to 16a on page 21)
- 9 DK }

23

d. Do you need help from another person in taking care of this device?

- 1 Yes
- 2 No
- 9 DK

24

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

16a. Do you have difficulty controlling urination?	1 <input type="checkbox"/> Yes (<i>Go to 16b</i>) 2 <input type="checkbox"/> No } (<i>Skip to 16c</i>) 9 <input type="checkbox"/> DK }	25
b. How frequently do you have this difficulty — daily, several times a week, once a week, or less than once a week? <i>Mark (X) only one.</i>	1 <input type="checkbox"/> Daily 2 <input type="checkbox"/> Several times a week 3 <input type="checkbox"/> Once a week 4 <input type="checkbox"/> Less than once a week 9 <input type="checkbox"/> DK	26
c. Do you have a urinary catheter or a device to help control urination?	1 <input type="checkbox"/> Yes (<i>Go to 16d</i>) 2 <input type="checkbox"/> No } (<i>Skip to Item G7</i>) 9 <input type="checkbox"/> DK }	27
d. Do you need help from another person in taking care of this device?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	28
ITEM G7	Status of SP. 1 <input type="checkbox"/> Institutionalized (<i>Skip to 27 on page 28</i>) 2 <input type="checkbox"/> All others (<i>Go to 17 on page 22</i>)	29

Notes

Section G – ASSISTANCE WITH KEY ACTIVITIES – Continued

READ TO RESPONDENT: These questions are about some other activities. Please tell me about doing them by yourself.

<p>Ask questions 17(H)–(J) before continuing to Item G8.</p> <p>17. Because of a health or physical problem, do you have ANY difficulty —</p> <p>Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p> <p>If "Yes", mark box 1; if "No" mark box 3.</p>	<p>(H) RT 24 3-4</p> <p>Preparing your own meals?</p>	<p>(I) RT 25 3-4</p> <p>Shopping for groceries and personal items, such as toilet items or medicines?</p>	<p>(J) RT 26 3-4</p> <p>Managing your money, such as keeping track of expenses or paying bills?</p>
<p>17.</p> <p>1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p>	<p>17.</p> <p>1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p>	<p>17.</p> <p>1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p>	<p>17.</p> <p>1 <input type="checkbox"/> Yes 5</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason Z</p> <p>Does someone else regularly do this for you?</p> <p>4 <input type="checkbox"/> Yes 6</p> <p>5 <input type="checkbox"/> No</p>

	<p>(H)</p> <p>Preparing your own meals</p>	<p>(I)</p> <p>Shopping for groceries and personal items</p>	<p>(J)</p> <p>Managing your money</p>
ITEM G8	<p>G8</p> <p>Refer to question 17. 7</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18)</p> <p>2 <input type="checkbox"/> All other (Go to G8 for next activity)</p>	<p>G8</p> <p>Refer to question 17. 7</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18)</p> <p>2 <input type="checkbox"/> All other (Go to G8 for next activity)</p>	<p>G8</p> <p>Refer to question 17. 7</p> <p>1 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18)</p> <p>2 <input type="checkbox"/> All other (Go to G8 for next activity)</p>
<p>18. By yourself, how much difficulty do you have (activity), — some, a lot, or are you unable to do it?</p>	<p>18.</p> <p>1 <input type="checkbox"/> Some } (Go to 19)</p> <p>2 <input type="checkbox"/> A lot } (Go to 19)</p> <p>3 <input type="checkbox"/> Unable (Go to G8 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 19)</p>	<p>18.</p> <p>1 <input type="checkbox"/> Some } (Go to 19)</p> <p>2 <input type="checkbox"/> A lot } (Go to 19)</p> <p>3 <input type="checkbox"/> Unable (Go to G8 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 19)</p>	<p>18.</p> <p>1 <input type="checkbox"/> Some } (Go to 19)</p> <p>2 <input type="checkbox"/> A lot } (Go to 19)</p> <p>3 <input type="checkbox"/> Unable (Go to G8 for next activity)</p> <p>9 <input type="checkbox"/> DK (Go to 19)</p>
<p>19. When you DO NOT HAVE HELP, is (activity) by yourself —</p> <p>a. Very tiring?</p> <p>b. Does (activity) take a long time?</p> <p>c. Is it very painful?</p>	<p>19a.</p> <p>0 <input type="checkbox"/> Never do without help (Go to G8 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>19b.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11</p> <p>19c.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12</p> <p>(Go to G8 for next activity)</p>	<p>19a.</p> <p>0 <input type="checkbox"/> Never do without help (Go to G8 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>19b.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11</p> <p>19c.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12</p> <p>(Go to G8 for next activity)</p>	<p>19a.</p> <p>0 <input type="checkbox"/> Never do without help (Go to G8 for next activity)</p> <p>Yes No DK</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>19b.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 11</p> <p>19c.</p> <p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 12</p> <p>(Go to G8 for next activity)</p>

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(K) Using the telephone? <small>RT 27 3-4</small>	(L) Doing heavy housework, like scrubbing floors, or washing windows? <small>RT 28 3-4</small>	(M) Doing light housework, like doing dishes, straightening up, or light cleaning? <small>RT 29 3-4</small>	(N) Getting to places outside of walking distance? <small>RT 30 3-4</small>	(O) Managing your medication? <small>RT 31 3-4</small>
17.	<input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 <input type="checkbox"/> No <input type="checkbox"/> Doesn't do for other reason <input checked="" type="checkbox"/> Does someone else regularly do this for you? <input type="checkbox"/> Yes 6 <input type="checkbox"/> No

	(K) Using the telephone	(L) Doing heavy housework	(M) Doing light housework	(N) Getting to places outside of walking distance	(O) Managing your medication
G8	Refer to question 17. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) <input type="checkbox"/> All other (Go to G8 for next activity)	Refer to question 17. 7 <input type="checkbox"/> Box 1 "Yes" marked (Go to 18) <input type="checkbox"/> All other (Skip to G9 on page 24)
18.	<input type="checkbox"/> Some } (Go to 19) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to G8 for next activity) <input type="checkbox"/> DK (Go to 19) 8	<input type="checkbox"/> Some } (Go to 19) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to G8 for next activity) <input type="checkbox"/> DK (Go to 19) 8	<input type="checkbox"/> Some } (Go to 19) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to G8 for next activity) <input type="checkbox"/> DK (Go to 19) 8	<input type="checkbox"/> Some } (Go to 19) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Go to G8 for next activity) <input type="checkbox"/> DK (Go to 19) 8	<input type="checkbox"/> Some } (Go to 19) <input type="checkbox"/> A lot } <input type="checkbox"/> Unable (Skip to G9 on page 24) <input type="checkbox"/> DK (Go to 19) 8
19a.	<input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10	<input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10	<input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10	<input type="checkbox"/> Never do without help (Go to G8 for next activity) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10	<input type="checkbox"/> Never do without help (Skip to G9 for activity (H)) 9 Yes No DK <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 10
b.	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 11
c.	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to G8 for next activity)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to G8 for next activity)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to G8 for next activity)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to G8 for next activity)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 12 (Go to G9 on page 24)

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(H) RT 24 Preparing your own meals	(I) RT 25 Shopping for groceries and personal items	(J) RT 26 Managing your money
ITEM G9	Refer to question 17 on page 22. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 22. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 22. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)
20a. Do you receive help from another person in (activity)?	20a. 14 1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	20a. 14 1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	20a. 14 1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }
b. Is this hands-on help?	b. 15 1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	b. 15 1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }	b. 15 1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK }
c. When you HAVE HANDS-ON HELP FROM ANOTHER PERSON, is (activity):	c. 16 0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17	c. 16 0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17	c. 16 0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> 17
(1) Very tiring?	(1) 17 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	(1) 17 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	(1) 17 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>
(2) Does (activity) take a long time?	(2) 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	(2) 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	(2) 18 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>
(3) Is it very painful?	(3) 19 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	(3) 19 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>	(3) 19 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>
d. How often do you have hands-on help with (activity)? Would you say always, sometimes, or rarely?	d. 20 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	d. 20 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	d. 20 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
e. Do you need (more) hands-on help with (activity)?	e. 21 1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	e. 21 1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	e. 21 1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

	(H) RT 24 Preparing your own meals	(I) RT 25 Shopping for groceries and personal items	(J) RT 26 Managing your money
ITEM G10	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)
21a. Do you have someone who supervises you or stays nearby when you are (activity)?	21a. 23 1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK }	21a. 23 1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK }	21a. 23 1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK }
b. Does this person provide —	b. 24	b. 24	b. 24
(1) Supervisory help, such as making sure the activity is performed correctly when you are (activity)?	(1) 24 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(1) 24 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(1) 24 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
(2) Stand-by help, such as observing to see if any help is needed when you are (activity)?	(2) 25 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) 25 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	(2) 25 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
22. How often do you have supervision or standby help when you are (activity)? Would you say always, sometimes, or rarely?	22. 26 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	22. 26 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK	22. 26 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK
23. Do you need (more) supervision or standby help with (activity)?	23. 27 1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	23. 27 1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }	23. 27 1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK }

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(K) RT 27	(L) RT 28	(M) RT 29	(N) RT 30	(O) RT 31
	Using the telephone	Doing heavy housework	Doing light housework	Getting to places outside of walking distance	Managing your medication
G9	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G9 for next activity) 2 <input type="checkbox"/> All others (Go to 20)	Refer to question 17 on page 23. 13 1 <input type="checkbox"/> Box 3 marked (Go to G10 for activity (H)) 2 <input type="checkbox"/> All others (Go to 20)
20a.	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 14	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 14	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 14	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 14	1 <input type="checkbox"/> Yes (Go to 20b) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 14
b.	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 15	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 15	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 15	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 15	1 <input type="checkbox"/> Yes (Go to 20c) 2 <input type="checkbox"/> No } (Skip to 20e) 9 <input type="checkbox"/> DK } 15
c.	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK } 16	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK } 16	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK } 16	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK } 16	0 <input type="checkbox"/> Never does activity (Skip to 20e) Yes No DK } 16
(1)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 17	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 17
(2)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 18	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 18
(3)	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 19	1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> } 19
d.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 20	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 20	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 20	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 20	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 20
e.	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 21	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 21	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 21	1 <input type="checkbox"/> Yes } (Go to G9 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 21	1 <input type="checkbox"/> Yes } (Go to G10 for activity (H)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 21

	(K) RT 27	(L) RT 28	(M) RT 29	(N) RT 30	(O) RT 31
	Using the telephone	Doing heavy housework	Doing light housework	Getting to places outside of walking distance	Managing your medication
G10	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Go to G10 for next activity) 2 <input type="checkbox"/> "Yes" marked in 20b (Go to G10 for next activity) 3 <input type="checkbox"/> Other (Go to 21)	Refer to G9 and 20b: 22 1 <input type="checkbox"/> Box 1 marked in G9 (Skip to G11 on page 26) 2 <input type="checkbox"/> "Yes" marked in 20b (Skip to G11 on page 26) 3 <input type="checkbox"/> Other (Go to 21)
21a.	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK } 23	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK } 23	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK } 23	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK } 23	1 <input type="checkbox"/> Yes (Go to 21b) 2 <input type="checkbox"/> No } (Skip to 23) 9 <input type="checkbox"/> DK } 23
b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 24	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 24	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 24	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 24	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 24
c.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 25	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 25	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 25	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 25	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } 25
22.	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 26	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 26	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 26	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 26	1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 9 <input type="checkbox"/> DK } 26
23.	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 27	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 27	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 27	1 <input type="checkbox"/> Yes } (Go to G10 for next activity) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 27	1 <input type="checkbox"/> Yes } (Skip to G11 on page 26 for activity (H)) 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> DK } 27

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(H) RT 24 Preparing your own meals	(I) RT 25 Shopping for groceries and personal items	
ITEM G11	G11 <i>Refer to 20a, 20e, 21a, and 23 on page 24.</i> 28 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (I))	G11 <i>Refer to 20a, 20e, 21a, and 23 on page 24.</i> 28 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (L))	
	24a. During the past month, did you experience discomfort because you were unable to eat when you were hungry because no one was available to prepare food? 29 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	24a. During the past month, were you unable to follow a special diet because you needed help shopping? 29 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	
	b. During the past month, were you unable to follow a special diet because you needed help cooking? 30 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	b. During the past month, did you miss a meal because you were unable to shop? 30 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Go to G11 for activity (L))	
	c. During the past month, were you unable to eat the kind of food you are used to and you prefer because you needed help cooking? 31 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Go to G11 for activity (I))		

	(H) RT 24 Prepare your own meals	(I) RT 25 Shop for groceries and personal items	(J) RT 26 Manage your money
ITEM G12	G12 <i>Refer to 17 on page 22.</i> 32 1 <input type="checkbox"/> Box 3 marked (Go to G12 for next activity) 2 <input type="checkbox"/> All other (Go to 25)	G12 <i>Refer to 17 on page 22.</i> 31 1 <input type="checkbox"/> Box 3 marked (Go to G12 for next activity) 2 <input type="checkbox"/> All other (Go to 25)	G12 <i>Refer to 17 on page 22.</i> 28 1 <input type="checkbox"/> Box 3 marked (Go to G12 for activity (L)) 2 <input type="checkbox"/> All other (Go to 25)
25. In your household, how often do YOU (activity)? Would you say always, sometimes, rarely, or never?	25. 33 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (Go to G12 for next activity)	25. 32 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (Go to G12 for next activity)	25. 29 1 <input type="checkbox"/> Always 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never 9 <input type="checkbox"/> DK } (Go to G12 for activity (L))

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

	(L) <small>RT 28</small> Doing heavy housework	(M) <small>RT 29</small> Doing light housework	(N) <small>RT 30</small> Getting to places outside of walking distance
	<p><i>Refer to 20a, 20e, 21a, and 23 on page 25.</i> <small>28</small></p> <p>G11 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (M))</p>	<p><i>Refer to 20a, 20e, 21a, and 23 on page 25.</i> <small>28</small></p> <p>G11 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Go to G11 for activity (N))</p>	<p><i>Refer to 20a, 20e, 21a, and 23 on page 25.</i> <small>28</small></p> <p>G11 1 <input type="checkbox"/> Any "Yes" (Go to 24) 2 <input type="checkbox"/> All other (Skip to G12 for activity (H))</p>
	<p>24. During the past month, did you experience distress because you were not able to wash clothes or clean up around the house?</p> <p>1 <input type="checkbox"/> Yes } <small>29</small> 2 <input type="checkbox"/> No } (Go to G11 for activity (M)) 9 <input type="checkbox"/> DK }</p>	<p>24. During the past month, did you experience distress because you were not able to do dishes or straighten up around the house?</p> <p>1 <input type="checkbox"/> Yes } <small>29</small> 2 <input type="checkbox"/> No } (Go to G11 for activity (N)) 9 <input type="checkbox"/> DK }</p>	<p>24a. During the past month, did you miss a doctor's or other medical appointment because you were unable to get there?</p> <p>1 <input type="checkbox"/> Yes <small>29</small> 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
			<p>b. During the past month, were you unable to go places you wanted to for fun or recreation because you did not have transportation?</p> <p>1 <input type="checkbox"/> Yes <small>30</small> 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
			<p>c. During the past month, did you run out of food because you were unable to get to the store?</p> <p>1 <input type="checkbox"/> Yes } <small>31</small> 2 <input type="checkbox"/> No } (Go to G12 for activity (H)) 9 <input type="checkbox"/> DK }</p>

	(L) Do heavy housework	(M) Do light housework	
	<p><i>Refer to 17 on page 23.</i> <small>30</small></p> <p>G12 1 <input type="checkbox"/> Box 3 marked (Go to G12 for next activity) 2 <input type="checkbox"/> All other (Go to 25)</p>	<p><i>Refer to 17 on page 23.</i> <small>30</small></p> <p>G12 1 <input type="checkbox"/> Box 3 marked (Skip to G13 on page 28) 2 <input type="checkbox"/> All other (Go to 25)</p>	
	<p>25. 1 <input type="checkbox"/> Always } <small>31</small> 2 <input type="checkbox"/> Sometimes } (Go to G12 for next activity) 3 <input type="checkbox"/> Rarely } 4 <input type="checkbox"/> Never } 9 <input type="checkbox"/> DK }</p>	<p>25. 1 <input type="checkbox"/> Always } <small>31</small> 2 <input type="checkbox"/> Sometimes } (Skip to G13 on page 28) 3 <input type="checkbox"/> Rarely } 4 <input type="checkbox"/> Never } 9 <input type="checkbox"/> DK }</p>	

Notes

Section G – ASSISTANCE WITH KEY ACTIVITIES – Continued

**ITEM
G13**

Refer to question 17 for activities H–O on pages 22 and 23. Indicate the activities marked "Yes".
Insert these marked activities when asking 26.

- H. Preparing your own meals
- I. Shopping for groceries and personal items
- J. Managing your money
- K. Using the telephone
- L. Doing heavy housework
- M. Doing light housework
- N. Getting to places outside of walking distance
- O. Managing your medication
- No activities marked (Skip to 27)

Insert activities marked in G13.

26a. What (other) condition causes the trouble in (activities)?

Record conditions and ask 26b.

Ask if operation:

For what condition did you have the operation?

Record up to 5 conditions.

- 00 No condition (Skip to 27)
- 01 Old age (Skip to 26c)

5-6

7-8

(a) _____ 9-10

(b) _____ 11-12

(c) _____ 13-14

(d) _____ 15-16

(e) _____ 17-18

b. Besides (condition), is there any other condition which causes this trouble in (activities)?

- 1 Yes (Reask 26a and b)
- 2 No } (Skip to 27)
- 9 DK }

19

c. Is this trouble in (activities) caused by any specific condition?

- 1 Yes (Reask 26a and b)
- 2 No } (Go to 27)
- 9 DK }

20

27a. During the past 12 months, that is, since (today's date) a year ago, have you fallen?

- 1 Yes (Go to 27b)
- 2 No } (Skip to Item G14 on page 29)
- 9 DK }

21

b. Have you fallen more than once during the past 12 months?

- 1 Yes
- 2 No
- 9 DK

22

c. Were you injured as a result of the fall(s)?

- 1 Yes (Go to 27d)
- 2 No } (Skip to 27e)
- 9 DK }

23

d. What kind of injuries did you have — a fracture, bruise, scrape or cut; did you lose consciousness, or did you have some other injury?

Mark (X) all that apply.

- 1 Fracture
- 2 Bruise, cut, or scrape
- 3 Lost consciousness
- 4 Other
- 9 DK

24

25

26

27

28

e. [Did you fall/Were any of these falls] because you did not have help getting around or because your helper could not prevent you from falling?

- 1 Yes
- 2 No
- 9 DK

29

f. [Did you fall/Were any of these falls] because you felt dizzy?

- 1 Yes
- 2 No
- 9 DK

30

Notes

Section G – ASSISTANCE WITH KEY ACTIVITIES – Continued

ITEM G14	Status of SP.	<input type="checkbox"/> Institutionalized (<i>Skip to 40 on page 33</i>) <input type="checkbox"/> All others (<i>Go to Item G15</i>)	31
ITEM G15	Refer to questions 8a, columns A, D, and G on pages 16–17. [Receives help] Mark (X) all that apply.	<input type="checkbox"/> "Yes" in 8a for A. Bathing <input type="checkbox"/> "Yes" in 8a for D. Getting in/out of bed/chairs <input type="checkbox"/> "Yes" in 8a for G. Using the toilet <input type="checkbox"/> All others (<i>Skip to 29</i>)	32 (Go to 28)
28. You said that you receive help with [bathing/(and) getting in or out of a bed or chair/(and) using the toilet]. Is the person who helps you most with [this/these activities] strong enough to give you the help you need or is helping physically difficult for him or her?		<input type="checkbox"/> Yes, strong enough <input type="checkbox"/> No, physically difficult <input type="checkbox"/> DK	33
If proxy respondent, ask; otherwise, skip to Item G16. 29. Does (sample person) need supervision to ensure [his/her] personal safety or the safety of others?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	34
ITEM G16	Refer to questions 8a and 9a on pages 16–17 and questions 20a and 21a on pages 24–25. (Receives help and/or supervision) Mark (X) all that apply.	<input type="checkbox"/> "Yes" in 8a or 9a for A. Bathing <input type="checkbox"/> "Yes" in 8a or 9a for B. Dressing <input type="checkbox"/> "Yes" in 8a or 9a for C. Eating <input type="checkbox"/> "Yes" in 8a or 9a for D. Getting in/out of bed/chairs <input type="checkbox"/> "Yes" in 8a or 9a for E. Walking <input type="checkbox"/> "Yes" in 8a or 9a for F. Getting outside <input type="checkbox"/> "Yes" in 8a or 9a for G. Using the toilet <input type="checkbox"/> "Yes" in 20a or 21a for H. Preparing your own meals <input type="checkbox"/> "Yes" in 20a or 21a for I. Shopping <input type="checkbox"/> "Yes" in 20a or 21a for J. Managing your money <input type="checkbox"/> "Yes" in 20a or 21a for K. Using the telephone <input type="checkbox"/> "Yes" in 20a or 21a for L. Doing heavy housework <input type="checkbox"/> "Yes" in 20a or 21a for M. Doing light housework <input type="checkbox"/> "Yes" in 20a or 21a for N. Getting places <input type="checkbox"/> "Yes" in 20a or 21a for O. Managing your medication <input type="checkbox"/> All others (<i>Skip to 38 on page 32</i>)	(Insert marked activities when asking question 30 on page 30)
Notes			

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

<p>30. Who usually helps you with (activities marked in G16)? Anyone else? Enter the name or description of each helper in separate column.</p>	30.	RT 33	3-4 5-6																																																								
<p>Ask 31-35 for each helper in 30. ASK OR VERIFY:</p> <p>31. Which activities does (Helper) help you with? Mark (X) all that apply.</p>	31.	(01) _____ First helper																																																									
<p>ASK OR VERIFY: HAND CARD A5. Read answers if telephone interview.</p> <p>32a. Which of these best describes (Helper)? Mark (X) only one.</p>	32a.	<table style="width:100%; border: none;"> <tr> <td style="width:5%;"><input type="checkbox"/> 01 Spouse</td> <td rowspan="2" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="2" style="vertical-align: middle;">In household</td> <td style="width:5%; text-align: right;">7-8</td> </tr> <tr> <td><input type="checkbox"/> 02 Child</td> <td style="text-align: right;">9-10</td> </tr> <tr> <td><input type="checkbox"/> 03 Parent</td> <td rowspan="4" style="font-size: 2em; vertical-align: middle;">}</td> <td rowspan="4" style="vertical-align: middle;">Not in household</td> <td style="text-align: right;">11-12</td> </tr> <tr> <td><input type="checkbox"/> 04 Spouse</td> <td style="text-align: right;">13-14</td> </tr> <tr> <td><input type="checkbox"/> 05 Child</td> <td style="text-align: right;">15-16</td> </tr> <tr> <td><input type="checkbox"/> 06 Parent</td> <td style="text-align: right;">17-18</td> </tr> <tr> <td><input type="checkbox"/> 07 Other HH relative</td> <td></td> <td></td> <td style="text-align: right;">19-20</td> </tr> <tr> <td><input type="checkbox"/> 08 Non-HH relative</td> <td></td> <td></td> <td style="text-align: right;">21-22</td> </tr> <tr> <td><input type="checkbox"/> 09 HH non-relative</td> <td></td> <td></td> <td style="text-align: right;">23-24</td> </tr> <tr> <td><input type="checkbox"/> 10 Friend/Neighbor</td> <td></td> <td></td> <td style="text-align: right;">25-26</td> </tr> <tr> <td><input type="checkbox"/> 11 Unpaid volunteer from organization/business</td> <td></td> <td></td> <td style="text-align: right;">27-28</td> </tr> <tr> <td><input type="checkbox"/> 12 Paid employee of organization/business</td> <td></td> <td></td> <td style="text-align: right;">29-30</td> </tr> <tr> <td><input type="checkbox"/> 13 Paid employee of yours</td> <td></td> <td></td> <td style="text-align: right;">31-32</td> </tr> <tr> <td><input type="checkbox"/> 14 Other</td> <td></td> <td></td> <td style="text-align: right;">33-34</td> </tr> <tr> <td><input type="checkbox"/> 15 Other</td> <td></td> <td></td> <td style="text-align: right;">35-36</td> </tr> <tr> <td><input type="checkbox"/> 99 DK</td> <td></td> <td></td> <td style="text-align: right;">37-38</td> </tr> </table>		<input type="checkbox"/> 01 Spouse	}	In household	7-8	<input type="checkbox"/> 02 Child	9-10	<input type="checkbox"/> 03 Parent	}	Not in household	11-12	<input type="checkbox"/> 04 Spouse	13-14	<input type="checkbox"/> 05 Child	15-16	<input type="checkbox"/> 06 Parent	17-18	<input type="checkbox"/> 07 Other HH relative			19-20	<input type="checkbox"/> 08 Non-HH relative			21-22	<input type="checkbox"/> 09 HH non-relative			23-24	<input type="checkbox"/> 10 Friend/Neighbor			25-26	<input type="checkbox"/> 11 Unpaid volunteer from organization/business			27-28	<input type="checkbox"/> 12 Paid employee of organization/business			29-30	<input type="checkbox"/> 13 Paid employee of yours			31-32	<input type="checkbox"/> 14 Other			33-34	<input type="checkbox"/> 15 Other			35-36	<input type="checkbox"/> 99 DK			37-38
<input type="checkbox"/> 01 Spouse	}	In household	7-8																																																								
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<input type="checkbox"/> 14 Other			33-34																																																								
<input type="checkbox"/> 15 Other			35-36																																																								
<input type="checkbox"/> 99 DK			37-38																																																								
<p>ASK OR VERIFY:</p> <p>b. Is (Helper) male or female?</p>	b.	<table style="width:100%; border: none;"> <tr> <td style="width:5%;"><input type="checkbox"/> 1 Male</td> <td style="width:5%; text-align: right;">41</td> </tr> <tr> <td><input type="checkbox"/> 2 Female</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 9 DK</td> <td></td> </tr> </table>		<input type="checkbox"/> 1 Male	41	<input type="checkbox"/> 2 Female		<input type="checkbox"/> 9 DK																																																			
<input type="checkbox"/> 1 Male	41																																																										
<input type="checkbox"/> 2 Female																																																											
<input type="checkbox"/> 9 DK																																																											
<p>If parent, child, spouse, or unpaid volunteer in 32a, skip to 34; otherwise ask:</p> <p>33a. Is (Helper) paid? HAND CARD A1. Read answers if telephone interview.</p> <p>b. Who pays for this help? (Anyone else?) Mark (X) all that apply.</p>	33a.	<table style="width:100%; border: none;"> <tr> <td style="width:5%;"><input type="checkbox"/> 1 Yes (Go to 33b)</td> <td style="width:5%; text-align: right;">42</td> </tr> <tr> <td><input type="checkbox"/> 2 No (Skip to 34)</td> <td></td> </tr> </table>		<input type="checkbox"/> 1 Yes (Go to 33b)	42	<input type="checkbox"/> 2 No (Skip to 34)																																																					
<input type="checkbox"/> 1 Yes (Go to 33b)	42																																																										
<input type="checkbox"/> 2 No (Skip to 34)																																																											
<p>34. DURING THE PAST 2 WEEKS, how many days did (Helper) help you?</p>	34.	<table style="width:100%; border: none;"> <tr> <td style="width:5%;"><input type="checkbox"/> 00 None in past 2 weeks</td> <td style="width:5%; text-align: right;">71-72</td> </tr> <tr> <td>_____ Days (Number)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 99 DK</td> <td></td> </tr> </table>		<input type="checkbox"/> 00 None in past 2 weeks	71-72	_____ Days (Number)		<input type="checkbox"/> 99 DK																																																			
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_____ Days (Number)																																																											
<input type="checkbox"/> 99 DK																																																											
<p>35. On the days you receive help from (Helper), about how many hours per day does [he/she] usually help you?</p>	35.	<table style="width:100%; border: none;"> <tr> <td style="width:5%;"><input type="checkbox"/> 99 DK</td> <td style="width:5%; text-align: right;">73-74</td> </tr> <tr> <td>_____ Hours/day (Number)</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: right;">} (Go to 31 for next helper, or G17)</td> </tr> </table>		<input type="checkbox"/> 99 DK	73-74	_____ Hours/day (Number)		} (Go to 31 for next helper, or G17)																																																			
<input type="checkbox"/> 99 DK	73-74																																																										
_____ Hours/day (Number)																																																											
} (Go to 31 for next helper, or G17)																																																											
<p>ITEM G17</p> <p>Refer to 30 above. (Number of helpers)</p>	G17	<table style="width:100%; border: none;"> <tr> <td style="width:5%;"><input type="checkbox"/> Only one helper (Skip to 37 on page 32)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> More than one helper (Go to 36 on page 32)</td> <td></td> </tr> </table>		<input type="checkbox"/> Only one helper (Skip to 37 on page 32)		<input type="checkbox"/> More than one helper (Go to 36 on page 32)																																																					
<input type="checkbox"/> Only one helper (Skip to 37 on page 32)																																																											
<input type="checkbox"/> More than one helper (Go to 36 on page 32)																																																											

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

36. You said that (Read all helpers) assist you. Who helps you the most? If 2 or more equally, ask the respondent to specify who he/she considers the main helper.

Helper No. _____

Name : _____

Ask 37 about only helper listed in 30 or main helper in 36.

37. How satisfied are you with —
- a. (Helper's) scheduled hours or availability when you need [him/her]? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?
 - b. The amount of assistance (helper) provides? (Would you say — (Read categories)?)
 - c. (Helper's) willingness to do what you ask? (Would you say — Read categories?)
 - d. (Helper's) ability to do what you need [him/her] to do? (Would you say — (Read categories)?)
If helper is present or related to SP, skip to 38; otherwise, ask:
How satisfied are you with —
 - e. (Helper's) reliability? (Would you say — (Read categories)?)
 - f. (Helper's) trustworthiness? (Would you say — (Read categories)?)
 - g. How (helper) treats you? (Would you say — (Read categories)?)

Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied	DK
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	9 <input type="checkbox"/>

38a. Including other persons living here, is there a friend, relative, or neighbor who would take care of you for a few DAYS, if necessary?

- 1 Yes (Go to 38b)
 - 2 No
 - 9 DK
- (Skip to 40 on page 33)

b. Who is this person?

Probe for description if necessary.

Mark (X) only one.

- 1 HH member - Related
- 2 HH member - Unrelated
- 3 Non HH member - Related
- 4 Non HH member - Unrelated
- 9 DK

Notes

Section G - ASSISTANCE WITH KEY ACTIVITIES - Continued

39a. Again, including other persons living here, is there a friend, relative, or neighbor who would take care of you for a few WEEKS, if necessary?	<input type="checkbox"/> Yes (Go to 39b) <input type="checkbox"/> No } (Skip to 40) <input type="checkbox"/> DK }	16
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b. Who is this person? <i>Probe for description if necessary.</i> <i>Mark (X) only one.</i>	<input type="checkbox"/> HH member - Related <input type="checkbox"/> HH member - Unrelated <input type="checkbox"/> Non HH member - Related <input type="checkbox"/> Non HH member - Unrelated <input type="checkbox"/> DK	17
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40a. [In the past 12 months/In the 12 months prior to moving to this (type of institution)], did you experience problems of any kind because you were home by yourself?	<input type="checkbox"/> Yes (Go to 40b) <input type="checkbox"/> No } (Skip to Item H1 on page 34) <input type="checkbox"/> DK }	18
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b. What kind of problems did you have? Anything else? <i>Read categories if necessary.</i> <i>Mark (X) all that apply.</i>	<input type="checkbox"/> Fall <input type="checkbox"/> Other accident or injury <input type="checkbox"/> Incontinence - No reminders <input type="checkbox"/> Incontinence - Unable to get to toilet <input type="checkbox"/> Confinement to bed or chairs <input type="checkbox"/> Hunger or thirst <input type="checkbox"/> Fire on stove/left stove on <input type="checkbox"/> Fell asleep while smoking <input type="checkbox"/> Got lost/wandered off <input type="checkbox"/> Forgot medications <input type="checkbox"/> Took wrong dose of medication (too much/little) <input type="checkbox"/> Fear <input type="checkbox"/> Other <input type="checkbox"/> DK	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>19-20</td></tr> <tr><td>21-22</td></tr> <tr><td>23-24</td></tr> <tr><td>25-26</td></tr> <tr><td>27-28</td></tr> <tr><td>29-30</td></tr> <tr><td>31-32</td></tr> <tr><td>33-34</td></tr> <tr><td>35-36</td></tr> <tr><td>37-38</td></tr> <tr><td>39-40</td></tr> <tr><td>41-42</td></tr> <tr><td>43-44</td></tr> <tr><td>45-46</td></tr> </table>	19-20	21-22	23-24	25-26	27-28	29-30	31-32	33-34	35-36	37-38	39-40	41-42	43-44	45-46
19-20																
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41-42																
43-44																
45-46																

Notes

Section H - OTHER SERVICES

ITEM H1	Status of SP.	<input type="checkbox"/> Institutionalized (Skip to Section I on page 39) <input type="checkbox"/> All others (Go to 1)	5																																				
Now I would like to ask about prescription medicines. 1. How many different prescription medicines are you supposed to use? Please count ones you should use each day and those that you use regularly but not every day. Include injections, eye drops, suppositories, creams, ointments, and skin patches, but not vitamins, oxygen, or medicines you get through an IV. <i>Mark (X) only one.</i>		<input type="checkbox"/> None (Skip to 9 on page 35) <input type="checkbox"/> One or two <input type="checkbox"/> Three - five <input type="checkbox"/> Six - nine <input type="checkbox"/> Ten or more <input type="checkbox"/> DK <p style="text-align: right;">} (Go to 2)</p>	6																																				
The next questions are about these prescription medicines. 2. Would you say that you use medicine(s) as prescribed by the doctor — (Read all categories) <i>Mark (X) only one.</i>		<input type="checkbox"/> All of the time, (Skip to 6) <input type="checkbox"/> Most of the time, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Rarely, or, <input type="checkbox"/> Never? <input type="checkbox"/> DK <p style="text-align: right;">} (Go to 3)</p>	7																																				
3. Are there any prescription medicines that you are supposed to use, but — a. did not get when first prescribed because of the cost? b. did not get the entire prescription filled because of the cost? c. did not refill when you ran out because of the cost? d. use less often than prescribed in order to stretch them out because of the cost? e. sometimes forget to use? f. don't use as prescribed because of the side effects? g. cannot pick up from the drug store or get delivered? h. don't use because you think you don't need it?		<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>DK</td> </tr> <tr> <td>a.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>g.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>h.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	No	DK	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 9 10 11 12 13 14 15
	Yes	No	DK																																				
a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																				
b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																				
c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																				
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g.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																				
h.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																				
4. Have you experienced any problems because you forgot to use your medicine or didn't use your medicine as prescribed?		<input type="checkbox"/> Yes (Go to 5) <input type="checkbox"/> No <input type="checkbox"/> DK } (Skip to 6)	16																																				
5. What problems did you experience? Anything else? <i>Mark (X) all that apply.</i>		<input type="checkbox"/> 01 Pain/Discomfort <input type="checkbox"/> 02 Dizziness/Fainting <input type="checkbox"/> 03 Disorientation <input type="checkbox"/> 04 Overdose/Withdrawal <input type="checkbox"/> 05 Change in blood pressure, breathing, or other vital signs <input type="checkbox"/> 06 Condition for which medicine prescribed got worse <input type="checkbox"/> 07 Other condition(s) got worse <input type="checkbox"/> 08 Had to be admitted to hospital <input type="checkbox"/> 09 Had to go to doctor/emergency room <input type="checkbox"/> 10 Drug reaction <input type="checkbox"/> 11 Other <input type="checkbox"/> 99 DK	17-18 19-20 21-22 23-24 25-26 27-28 29-30 31-32 33-34 35-36 37-38 39-40																																				
6. Do you receive help using your medications? This includes reminding you or measuring the medicines, and setting them up for you, OR do you use ALL of your medicine completely by yourself? <i>Mark (X) only one.</i>		<input type="checkbox"/> Receive help <input type="checkbox"/> All by self <input type="checkbox"/> DK	41																																				
7. Not counting financial help, do you NEED (more) help with your medicine?		<input type="checkbox"/> Yes (Go to 8) <input type="checkbox"/> No <input type="checkbox"/> DK } (Skip to 9 on page 35)	42																																				
8. What do you NEED (more) help with? <i>Mark (X) all that apply.</i>		<input type="checkbox"/> Ordering/Shopping for/Getting medicines from pharmacy <input type="checkbox"/> Reminder/Monitoring/Measuring/Setting up/Taking medicines <input type="checkbox"/> Other <input type="checkbox"/> DK	43 44 45 46																																				

Section H - OTHER SERVICES - Continued

These next questions are about your sources of medical care.		47
9. Do you have a general practitioner, internist, or family doctor whom you see regularly?	1 <input type="checkbox"/> Yes (<i>Go to 10</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>Skip to 14 on page 36</i>)	
10. Which do you see most often — a general practitioner, an internist, or family doctor? <i>Mark (X) only one.</i>	1 <input type="checkbox"/> General practitioner 2 <input type="checkbox"/> Internist 3 <input type="checkbox"/> Family doctor 4 <input type="checkbox"/> DK specialty/title 9 <input type="checkbox"/> DK which seen most often	48
11. Have you seen this [(<i>provider in 10</i>) doctor] in the past 12 months?	1 <input type="checkbox"/> Yes (<i>Go to 12</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>Skip to 13</i>)	49
12. In the past 3 months, how many times have you seen this [(<i>provider in 10</i>) doctor]?	00 <input type="checkbox"/> None ____ Times (Number) 99 <input type="checkbox"/> DK	50-51
13. How would you rate this [(<i>provider in 10</i>) doctor] in terms of overall quality of care and services? Would you say excellent, good, fair, or poor? <i>Mark (X) only one.</i>	1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Good 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Poor 9 <input type="checkbox"/> DK	52

Notes

Section H - OTHER SERVICES - Continued		RT 36 3-4	RT 36 3-4
		A	B
The next questions are about other services you may have received.		1	2
		A visiting nurse	A personal care attendant (other than family or a friend)
14a. During the past 12 months, did you receive any services from ____?		5	5
		14a.	14a.
		1 <input type="checkbox"/> Yes (Skip to 15)	1 <input type="checkbox"/> Yes (Skip to 15)
		2 <input type="checkbox"/> No } (Go to 14b)	2 <input type="checkbox"/> No } (Go to 14b)
		9 <input type="checkbox"/> DK } (Go to 14b)	9 <input type="checkbox"/> DK } (Go to 14b)
b. Did you need the services of ____ in the past 12 months?		6	6
		b.	b.
		1 <input type="checkbox"/> Yes (Skip to 18)	1 <input type="checkbox"/> Yes (Skip to 18)
		2 <input type="checkbox"/> No } (Go to 14a for next service)	2 <input type="checkbox"/> No } (Go to 14a for next service)
		9 <input type="checkbox"/> DK } (Go to 14a for next service)	9 <input type="checkbox"/> DK } (Go to 14a for next service)
15a. During the past 12 months, in how many months did you receive services from ____?		7	7
		15a.	15a.
		____ Months	____ Months
		(Number)	(Number)
		99 <input type="checkbox"/> DK	99 <input type="checkbox"/> DK
b. What was the total number of times you received services from ____ during [that/those] month(s)?		8-9	8-9
		b.	b.
		____ Times	____ Times
		(Number)	(Number)
		99 <input type="checkbox"/> DK	99 <input type="checkbox"/> DK
<i>HAND CARD A1. Read categories if telephone interview.</i>			
16a. Who paid or will pay for the services received from ____ in the past 12 months?			
(Anyone else?)			
Mark (X) all that apply.			
		16a.	16a.
		01 <input type="checkbox"/> Self or family in household	01 <input type="checkbox"/> Self or family in household
		02 <input type="checkbox"/> Family NOT in household	02 <input type="checkbox"/> Family NOT in household
		03 <input type="checkbox"/> Private health insurance	03 <input type="checkbox"/> Private health insurance
		04 <input type="checkbox"/> Medicare	04 <input type="checkbox"/> Medicare
		05 <input type="checkbox"/> Medicaid	05 <input type="checkbox"/> Medicaid
		06 <input type="checkbox"/> Rehabilitation program	06 <input type="checkbox"/> Rehabilitation program
		07 <input type="checkbox"/> Employer	07 <input type="checkbox"/> Employer
		08 <input type="checkbox"/> School system	08 <input type="checkbox"/> School system
		09 <input type="checkbox"/> VA program	09 <input type="checkbox"/> VA program
		10 <input type="checkbox"/> Other military	10 <input type="checkbox"/> Other military
		11 <input type="checkbox"/> Other private source	11 <input type="checkbox"/> Other private source
		12 <input type="checkbox"/> Other public source	12 <input type="checkbox"/> Other public source
		13 <input type="checkbox"/> No one/ Free } (Skip to 17)	13 <input type="checkbox"/> No one/ Free } (Skip to 17)
		99 <input type="checkbox"/> DK } (Skip to 17)	99 <input type="checkbox"/> DK } (Skip to 17)
		40-41	40-41
<i>Ask if more than one source in 16a. If only one, transcribe number of box marked without asking.</i>			
b. Who paid most of the cost for the services received from ____ in the past 12 months? Record number of main source.			
		b.	b.
		<input type="checkbox"/> Paid most	<input type="checkbox"/> Paid most
		(Number)	(Number)
		99 <input type="checkbox"/> DK	99 <input type="checkbox"/> DK
<i>Ask only if box 01 marked in 16a; otherwise, skip to 17.</i>			
c. During the past 12 months, about how much did you or your family pay for the services received from ____? Do not count any money that has been or will be reimbursed by insurance or any other source.			
		c.	c.
		00000 <input type="checkbox"/> None	00000 <input type="checkbox"/> None
		\$ _____ 00	\$ _____ 00
		99999 <input type="checkbox"/> DK	99999 <input type="checkbox"/> DK
		42-46	42-46
17. During (month) did you receive services from ____?		47	47
		17.	17.
		1 <input type="checkbox"/> Yes (Skip to 14a for next service)	1 <input type="checkbox"/> Yes (Skip to 14a for next service)
		2 <input type="checkbox"/> No (Go to 18)	2 <input type="checkbox"/> No (Go to 18)
		9 <input type="checkbox"/> DK (Skip to 14a for next service)	9 <input type="checkbox"/> DK (Skip to 14a for next service)
<i>HAND CARD A7. Read categories if telephone interview.</i>			
18. Why didn't you receive services from ____ [in (month)] in the past 12 months?			
(Anything else?)			
Mark (X) all that apply.			
		18.	18.
		00 <input type="checkbox"/> Didn't need services	00 <input type="checkbox"/> Didn't need services
		01 <input type="checkbox"/> Provider thinks no longer needed	01 <input type="checkbox"/> Provider thinks no longer needed
		02 <input type="checkbox"/> Too expensive/ can't afford	02 <input type="checkbox"/> Too expensive/ can't afford
		03 <input type="checkbox"/> Insurance doesn't cover	03 <input type="checkbox"/> Insurance doesn't cover
		04 <input type="checkbox"/> Insurance no longer covers	04 <input type="checkbox"/> Insurance no longer covers
		05 <input type="checkbox"/> No longer on Medicaid	05 <input type="checkbox"/> No longer on Medicaid
		06 <input type="checkbox"/> Provider not available	06 <input type="checkbox"/> Provider not available
		07 <input type="checkbox"/> Didn't like provider	07 <input type="checkbox"/> Didn't like provider
		08 <input type="checkbox"/> Transportation problems	08 <input type="checkbox"/> Transportation problems
		09 <input type="checkbox"/> Could not take time off from work	09 <input type="checkbox"/> Could not take time off from work
		10 <input type="checkbox"/> Other	10 <input type="checkbox"/> Other
		99 <input type="checkbox"/> DK	99 <input type="checkbox"/> DK
		48-49	48-49
		50-51	50-51
		52-53	52-53
		54-55	54-55
		56-57	56-57
		58-59	58-59
		60-61	60-61
		62-63	62-63
		64-65	64-65
		66-67	66-67
		68-69	68-69
		70-71	70-71

C

Notes

3 An adult day care center or day activity center 5

14a. 1 Yes (Skip to 15) 6
2 No } (Go to 14b)
9 DK }

b. 1 Yes (Skip to 18) 7
2 No } (Skip to 19 on
9 DK } page 38)

15a. _____ Months 8-9
(Number)
99 DK

b. _____ Times 10-11
(Number)
99 DK

- 16a. 01 Self or family in household 12-13
- 02 Family NOT in household 14-15
- 03 Private health insurance 16-17
- 04 Medicare 18-19
- 05 Medicaid 20-21
- 06 Rehabilitation program 22-23
- 07 Employer 24-25
- 08 School system 26-27
- 09 VA program 28-29
- 10 Other military 30-31
- 11 Other private source 32-33
- 12 Other public source 34-35
- 13 No one/Free } (Skip to 17) 36-37
- 99 DK } 38-39

b. [] [] Paid most (Number) 40-41
99 DK

c. 00000 None 42-46
\$ _____ 00
99999 DK

17. 1 Yes (Skip to 19 on page 38) 47
2 No (Go to 18)
9 DK (Skip to 19 on page 38)

- 18. 00 Didn't need services 48-49
- 01 Provider thinks no longer needed 50-51
- 02 Too expensive/ can't afford 52-53
- 03 Insurance doesn't cover 54-55
- 04 Insurance no longer covers 56-57
- 05 No longer on Medicaid 58-59
- 06 Provider not available 60-61
- 07 Didn't like provider 62-63
- 08 Transportation problems 64-65
- 09 Could not take time off from work 66-67
- 10 Other 68-69
- 99 DK 70-71

Section H - OTHER SERVICES - Continued

19a. Are you currently on a waiting list for services from a visiting nurse, personal care attendant, or an adult day care or day activity center?

72

- 1 Yes (Go to 19b)
- 2 No } Skip to 20
- 9 DK }

b. For which of these services are you on a waiting list?

*Read list if necessary.
Mark (X) all that apply.*

- 01 A visiting nurse
- 02 A personal care attendant, other than family or a friend
- 03 An adult day care center or day activity center
- 09 DK

73-74
75-76
77-78
79-80

20a. Do you NEED help filling out insurance forms or benefit applications?

81

Mark (X) only one.

- 1 Yes } (Go to 20b)
- 2 No }
- 3 Never filled forms/applications (Skip to Section I on page 39)
- 9 DK (Go to 20b)

b. Who helps you fill out insurance forms or applications for public programs or benefits?

Mark (X) all that apply.

- 0 No one
- 1 Household member
- 2 Friend/Other relative not in household
- 3 Paid caregiver
- 4 Volunteer from organization
- 5 Other
- 9 DK

82
83
84
85
86
87
88

Notes

Section I - FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS

1. Are you now married, widowed, divorced, separated, or have you never been married?
If married, probe as necessary to determine if the spouse is a current household member.
Mark (X) only one.

Married - spouse in HH
 Married - spouse not in HH } (Go to 2a)
 Widowed
 Divorced } (Go to 2b)
 Separated
 Never married } (Skip to Item 11)
 DK

2a. How long have you been married to your current spouse?

Less than 1 year
 _____ Years
 (Number)
 DK

(Skip to Item 11)

b. How long have you been [widowed/divorced/separated]?

Less than 1 year
 _____ Years
 (Number)
 DK

ITEM 11 Status of SP.

Institutionalized (Skip to 5 on page 40)
 All others (Go to 3)

3. Including yourself, how many people altogether live in this household?

SP only (Skip to 5 on page 40)
 _____ Household members (Go to 4)
 (Number)
 DK (Go to 4)

4a. What are the names of all persons living in your household?
Enter SP on line 1, all others on subsequent lines.
If more than 9 household members, continue listing in the Notes space.

b. If necessary, ask: What is (name's) sex?

c. If necessary, ask: How is (name) related TO YOU? Record relationships to the sample person.

Line No.	4a. Name (First/Middle initial/Last)	b. Sex	c. Relationship to Sample Person
3-4 5-6 01	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	77 <input type="checkbox"/> SAMPLE PERSON
3-4 5-6 02	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 03	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 04	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 05	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 06	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 07	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 08	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	
3-4 5-6 09	7-57	58 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	

Section I - FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS - Continued

<p>5a. Including step and adopted children, how many LIVING SONS do you have?</p>	<p>00 <input type="checkbox"/> None _____ Sons (Number) 99 <input type="checkbox"/> DK</p>	<p>5-6</p>
<p>b. Including step and adopted children, how many LIVING DAUGHTERS do you have?</p>	<p>00 <input type="checkbox"/> None _____ Daughters (Number) 99 <input type="checkbox"/> DK</p>	<p>7-8</p>

<p>ITEM 12</p>	<p>Refer to 5a and 5b. (Living children)</p>	<p>1 <input type="checkbox"/> 1+ living children (Go to Item 13) 2 <input type="checkbox"/> All others (Skip to Item 14 on page 41)</p>	<p>9</p>
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<p>ITEM 13</p>	<p>Refer to question 4 on page 39. (Household composition)</p>	<p>1 <input type="checkbox"/> Any of SP's child(ren) in HH (Skip to 7) 2 <input type="checkbox"/> All others (Go to 6)</p>	<p>10</p>
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<p>6a. How quickly can [any of your children/your son/your daughter] get here? <i>If asked, "Here" means where the SP resides.</i></p>	<p>_____ { 1 <input type="checkbox"/> Minutes (Number) { 2 <input type="checkbox"/> Hours { 3 <input type="checkbox"/> Days 999 <input type="checkbox"/> DK</p>	<p>11-13</p>
--	--	--------------

<p>b. How often do you see [any of your children/your son/your daughter]?</p>	<p>000 <input type="checkbox"/> Less than once a year/never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK</p>	<p>14-16</p>
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<p>c. How often do you talk on the telephone with [any of your children/your son/your daughter]?</p>	<p>000 <input type="checkbox"/> Less than once a year/never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK</p>	<p>17-19</p>
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<p>d. How often do you get mail from [any of your children/your son/your daughter]?</p>	<p>000 <input type="checkbox"/> Less than once a year/never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK</p>	<p>20-22</p>
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<p>7. [Do your children/Does your son/Does your daughter] routinely give you money to help with your living expenses or pay your bills?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>23</p>
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Notes

Section I – FAMILY STRUCTURE, RELATIONSHIPS, AND LIVING ARRANGEMENTS – Continued

<p>ITEM 14</p>	<p>Refer to question 4 on page 39. (Household composition) Mark (X) first appropriate box.</p>	<p>1 <input type="checkbox"/> SP is institutionalized 2 <input type="checkbox"/> SP lives alone 3 <input type="checkbox"/> SP lives w/spouse only 4 <input type="checkbox"/> Other (Go to 8)</p> <p align="right">} (Skip to 11)</p>	<p align="right">24</p>
<p>8. (Other than your spouse) [is/are any of] the person(s) living with you 18 years of age or older?</p>		<p>1 <input type="checkbox"/> Yes (Go to 9) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p align="right">} (Skip to 11)</p>	<p align="right">25</p>
<p>9. Do you live with [these people/this person] NOW because YOU need to share living expenses?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">26</p>
<p>10. Do you live with [these people/this person] NOW because of a health or physical problem YOU have?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">27</p>
<p>11. Including step and adopted brothers, how many LIVING brothers do you have?</p>		<p>00 <input type="checkbox"/> None _____ Brothers (Number) 99 <input type="checkbox"/> DK</p>	<p align="right">28-29</p>
<p>12. Including step and adopted sisters, how many LIVING sisters do you have?</p>		<p>00 <input type="checkbox"/> None _____ Sisters (Number) 99 <input type="checkbox"/> DK</p>	<p align="right">30-31</p>
<p>ASK OR VERIFY: 13a. Is your mother still living?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">32</p>
<p>b. Is your father still living?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">33</p>
<p>ITEM 15</p>	<p>Refer to Item 14. (SP's living arrangement)</p>	<p>1 <input type="checkbox"/> Box 1, 2, or 3 marked (Go to 14) 2 <input type="checkbox"/> Box 4 marked (Skip to 15)</p>	<p align="right">34</p>
<p>The next few questions are about contact you have with family members (other than your spouse or children). 14a. How quickly can any member of your family (other than your spouse or children) get here? <i>If asked, "Here" means where the SP resides.</i></p>		<p>000 <input type="checkbox"/> No other family (Skip to Section J on page 42) _____ { 1 <input type="checkbox"/> Minutes (Number) { 2 <input type="checkbox"/> Hours { 3 <input type="checkbox"/> Days 999 <input type="checkbox"/> DK</p>	<p align="right">35-37</p>
<p>b. How often do you see any member of your family (other than your spouse or children)?</p>		<p>000 <input type="checkbox"/> Less than once a year/Never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK</p>	<p align="right">38-40</p>
<p>c. How often do you talk on the telephone with any member of your family (other than your spouse or children)?</p>		<p>000 <input type="checkbox"/> Less than once a year/Never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK</p>	<p align="right">41-43</p>
<p>d. How often do you get mail from any member of your family (other than your spouse or children)?</p>		<p>000 <input type="checkbox"/> Less than once a year/Never _____ { 1 <input type="checkbox"/> Per day (Times) { 2 <input type="checkbox"/> Per week { 3 <input type="checkbox"/> Per month { 4 <input type="checkbox"/> Per year 999 <input type="checkbox"/> DK</p>	<p align="right">44-46</p>
<p>15. Do any members of your family (other than your spouse or children) routinely give you money to help with your living expenses or pay your bills?</p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p align="right">47</p>

Section J - CONDITIONS AND IMPAIRMENTS

Now I'm going to ask some questions about vision and hearing. Please tell me if you have any of the following conditions, even if you have mentioned them before.

1. Do you NOW have --		Yes	No	DK	
a. Cataracts?	a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	5
b. Glaucoma?	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	6
c. Blindness in both eyes?	c.	1 <input type="checkbox"/> (Skip to 3)	2 <input type="checkbox"/>	9 <input type="checkbox"/>	7
d. Blindness in one eye?	d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	8
e. Any other trouble seeing with one or both eyes, EVEN when wearing glasses?	e.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	9
2a. Do you use eyeglasses? Include eyeglasses that just magnify.		1 <input type="checkbox"/> Yes (Go to 2b) 2 <input type="checkbox"/> No } (Skip to 2c) 9 <input type="checkbox"/> DK }			10
b. Were these eyeglasses prescribed for you?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			11
c. Do you use contact lenses?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			12
3. Have you EVER had an operation for cataracts?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			13
ITEM J1	Refer to 1c above. (Blind in both eyes)	1 <input type="checkbox"/> "Yes" marked in 1c (Skip to 6) 2 <input type="checkbox"/> All others (Go to 4)			14
4. Do you have a lens implant?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			15
5. Do you use a magnifying glass to read or to do other close work?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK			16
6. Do you NOW have --		Yes	No	DK	
a. Deafness in both ears?	a.	1 <input type="checkbox"/> (Skip to 7)	2 <input type="checkbox"/>	9 <input type="checkbox"/>	17
b. Deafness in one ear?	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	18
c. Any other trouble hearing with one or both ears?	c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	19

Notes

Section J - CONDITIONS AND IMPAIRMENTS - Continued

Now I'm going to ask about some other conditions. Again, please tell me if you ever had any of these conditions, even if you have mentioned them before.

Ask all of 7a (1)-(11) before going to 7b-d across.

Ask 7b-d as appropriate for each "Yes" in 7a.

7a. Have you EVER had —

b. In what year [did/was] (condition) first [occur/noticed]?

c. Did a doctor ever tell you that you had (condition)?

d. Do you still have (condition)?

(1) A broken hip?

- 1 Yes
2 No
9 DK

20

(1) 21-22
19 ____ Year
99 DK

(2) Osteoporosis?

- 1 Yes
2 No
9 DK

23

(2) 24-25
19 ____ Year
99 DK

(2) 1 Yes
2 No
9 DK

26

(3) Diabetes?

- 1 Yes
2 No
9 DK

27

(3) 28-29
19 ____ Year
99 DK

(3) 1 Yes
2 No
9 DK

30

(3) 1 Yes
2 No
9 DK

31

(4) Arthritis?

- 1 Yes
2 No
9 DK

32

(4) 33-34
19 ____ Year
99 DK

(4) 1 Yes
2 No
9 DK

35

(5) Chronic bronchitis or emphysema?

- 1 Yes
2 No
9 DK

36

(5) 37-38
19 ____ Year
99 DK

(5) 1 Yes
2 No
9 DK

39

(5) 1 Yes
2 No
9 DK

40

(6) Asthma?

- 1 Yes
2 No
9 DK

41

(6) 42-43
19 ____ Year
99 DK

(6) 1 Yes
2 No
9 DK

44

(6) 1 Yes
2 No
9 DK

45

(7) Hypertension, sometimes called high blood pressure?

- 1 Yes
2 No
9 DK

46

(7) 47-48
19 ____ Year
99 DK

(7) 1 Yes
2 No
9 DK

49

(7) 1 Yes
2 No
9 DK

50

(8) Heart disease, including coronary heart disease, angina, heart attack or myocardial infarction?

- 1 Yes
2 No
9 DK

51

(8) 52-53
19 ____ Year
99 DK

(8) 1 Yes
2 No
9 DK

54

(9) Any other heart disease?

- 1 Yes
2 No
9 DK

55

(9) 56-57
19 ____ Year
99 DK

(9) 1 Yes
2 No
9 DK

58

(10) A stroke or cerebrovascular accident?

- 1 Yes
2 No
9 DK

59

(10) 60-61
19 ____ Year
99 DK

(10) 1 Yes
2 No
9 DK

62

(11) Cancer of any kind?

- 1 Yes
2 No
9 DK

63

(11) 64-65
19 ____ Year
99 DK

(11) 1 Yes
2 No
9 DK

66

(11) 1 Yes
2 No
9 DK

67

ITEM J2

Refer to 7a (11).
(Cancer of any kind)

- 1 "Yes" marked in 7a (11) (Go to 8)
2 All others (Skip to 9 on page 44)

68

HAND CARD A19. Read categories if telephone interview.

8. What kind of cancer [is/was] it? (Anything else?)

Mark (X) all that apply.

- 01 Colon/rectal/bowel
02 Skin - melanoma
03 Skin - nonmelanoma
04 Skin - unknown type
05 Uterine/ovarian
06 Prostate
07 Stomach
08 Leukemia
09 Breast
10 Cervical
11 Lung
12 Other
99 DK

- 69-70
71-72
73-74
75-76
77-78
79-80
81-82
83-84
85-86
87-88
89-90
91-92
93-94

Section J - CONDITIONS AND IMPAIRMENTS - Continued

9a. Do you sometimes have trouble with dizziness?

- 1 Yes *(Go to 9b)*
- 2 No
- 9 DK } *(Skip to 10)*

95

b. Does dizziness prevent you in any way from doing things you otherwise could do?

- 1 Yes
- 2 No
- 9 DK

96

10. Do you have trouble biting or chewing any kinds of food, such as firm meat or apples?

If asked, this includes while wearing false teeth or dentures.

- 1 Yes
- 2 No
- 9 DK

97

Notes

Section K – HEALTH OPINIONS AND BEHAVIORS

RT 41
3-4

<p><i>READ TO RESPONDENT – Now I'd like to ask your personal opinions about health related matters.</i></p> <p>1. Would you say your health in general is excellent, very good, good, fair, or poor?</p>	<p>1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor 9 <input type="checkbox"/> DK</p>	5
<p><i>If proxy respondent, skip to 3; otherwise ask:</i></p> <p>2. In the past 12 months, how often did you feel sad or depressed? Would you say you were sad or depressed — (Read all categories)</p> <p><i>Mark (X) only one.</i></p>	<p>1 <input type="checkbox"/> All of the time, 2 <input type="checkbox"/> Some of the time, 3 <input type="checkbox"/> A little of the time, or 4 <input type="checkbox"/> None of the time? 9 <input type="checkbox"/> DK</p>	6
<p>3. Compared to your own level of physical activity 1 year ago, would you say you are now more active, less active, or about the same as you were then?</p> <p><i>Mark (X) only one.</i></p>	<p>1 <input type="checkbox"/> More active 2 <input type="checkbox"/> Less active 3 <input type="checkbox"/> About the same 9 <input type="checkbox"/> DK</p>	7
<p>4. Do you follow a REGULAR routine of physical exercise?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	8
<p>5. About how tall are you without shoes?</p>	<p>_____ Feet _____ Inches</p> <p>999 <input type="checkbox"/> DK</p>	9-11
<p>6. About how much do you weigh without shoes?</p>	<p>_____ Pounds</p> <p>999 <input type="checkbox"/> DK</p>	12-14
<p><i>If proxy respondent, skip to 8; otherwise ask:</i></p> <p>7. What was your usual weight at the age of 50?</p>	<p>_____ Pounds</p> <p>999 <input type="checkbox"/> DK</p>	15-17
<p>8. Have you smoked at least 100 cigarettes in your entire life?</p> <p><i>If asked: Approximately 5 packs.</i></p>	<p>1 <input type="checkbox"/> Yes (Go to 9) 2 <input type="checkbox"/> No } (Skip to 11) 9 <input type="checkbox"/> DK }</p>	18
<p>9. Do you NOW smoke cigarettes every day, some days, or not at all?</p>	<p>1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Some days 3 <input type="checkbox"/> Not at all 9 <input type="checkbox"/> DK</p>	19
<p>10. For how many years [have you smoked/did you smoke] cigarettes?</p>	<p>00 <input type="checkbox"/> Less than 1 year</p> <p>_____ Years (Number)</p> <p>99 <input type="checkbox"/> DK</p>	20-21
<p>11. Now I would like to ask you about drinking alcoholic beverages. By alcoholic beverages I mean beer, wine, or liquor. Have you had at least one drink of beer, wine, or liquor during the past year?</p>	<p>1 <input type="checkbox"/> Yes (Go to 12) 2 <input type="checkbox"/> No } (Skip to Section L on page 46) 9 <input type="checkbox"/> DK }</p>	22
<p>12. During the past year, on the average, on how many days did you drink alcoholic beverages, that is beer, wine, or liquor?</p>	<p>0000 <input type="checkbox"/> Every day</p> <p>_____ Days { 1 <input type="checkbox"/> Per week (Number) 2 <input type="checkbox"/> Per month 3 <input type="checkbox"/> Per year</p> <p>9999 <input type="checkbox"/> DK</p>	23-26
<p>13. On [the/those] day(s) when you drank, about how many drinks would you say you had?</p>	<p>_____ Drinks (Number)</p> <p>99 <input type="checkbox"/> DK</p>	27-28

Section L - COMMUNITY SERVICES

NOTE - Ask 2 immediately after a "Yes" in 1a-f.

READ TO RESPONDENT - The next questions are about community services.

1. [In the past 12 months/in the 12 months prior to coming to this (type of institution)], did you —

2. How often did you use it — frequently, sometimes, or rarely?

a. Use a senior center?

- 1 Yes (Go to 2a) 29
 2 No } (Go to 1b)
 9 DK }

a.

- 1 Frequently } 30
 2 Sometimes } (Go to 1b)
 3 Rarely }
 9 DK }

b. Use special transportation for the elderly?

- 1 Yes (Go to 2b) 31
 2 No } (Go to 1c)
 9 DK }

b.

- 1 Frequently } 32
 2 Sometimes } (Go to 1c)
 3 Rarely }
 9 DK }

c. Have meals delivered to your home by an agency or organization like Meals on Wheels?

- 1 Yes (Go to 2c) 33
 2 No } (Go to 1d)
 9 DK }

c.

- 1 Frequently } 34
 2 Sometimes } (Go to 1d)
 3 Rarely }
 9 DK }

d. Eat meals in a senior center or in some place with a special meal program for the elderly?

- 1 Yes (Go to 2d) 35
 2 No } (Go to 1e)
 9 DK }

d.

- 1 Frequently } 36
 2 Sometimes } (Go to 1e)
 3 Rarely }
 9 DK }

e. Use a homemaker service for the elderly that provides services like cleaning and cooking in the home?

- 1 Yes (Go to 2e) 37
 2 No } (Go to 1f)
 9 DK }

e.

- 1 Frequently } 38
 2 Sometimes } (Go to 1f)
 3 Rarely }
 9 DK }

f. Use information and referral services?

- 1 Yes (Go to 2f) 39
 2 No } (Go to
 9 DK } Section M
 on page 47)

f.

- 1 Frequently } 40
 2 Sometimes } (Go to
 3 Rarely } Section M
 9 DK } on page 47)

Notes

Section M - UPDATE CONTACT PERSON INFORMATION

The National Center for Health Statistics may wish to contact you again to obtain additional health related information.

ITEM M1	Refer to CP on label.	1 <input type="checkbox"/> CP on label (Ask 1a) 2 <input type="checkbox"/> No CP on label (Ask 1b)	5
----------------	-----------------------	---	---

1a. The last time a Census Bureau interviewer talked to you or your family, we were told that (CP on label) will always know how to get in touch with you if we want to contact you again. Is (CP on label) still the best person to contact if we are unable to reach you?	1 <input type="checkbox"/> Yes (Verify CP's address and phone number. If incorrect, enter correct information in 2 below.) 2 <input type="checkbox"/> No (Go to 1b)	6
--	--	---

b. The National Center for Health Statistics would like the name, address, and telephone number of a relative or friend who would know where you could be reached in case we need additional health information in the future but cannot reach you. Please give me the name of someone who is not currently living in the household.

(Record information in 2.)

2. Contact Person current information

Last name	7-26	First name	27-41	MI	42
Number and street					43-67
City	68-87	State	88-89	ZIP Code	90-98
Telephone					
Area code	99-101	Number	102-108	1 <input type="checkbox"/> None 9 <input type="checkbox"/> DK 7 <input type="checkbox"/> Refused	
109					

Notes

Section N - INTERVIEWER OBSERVATIONS

ITEM N1	<i>Mark (X) the one that best represents this interview.</i>	1 <input type="checkbox"/> Self response without assistance (<i>Skip to 3</i>) 2 <input type="checkbox"/> Self response with assistance (<i>Go to 1a</i>) 3 <input type="checkbox"/> Proxy (<i>Skip to 1b</i>)	5
--------------------	--	--	---

ASK OR VERIFY: 1a. How is (assistant) related to you? <i>If more than one assistant, indicate the relationship of the one you consider to be the main assistant.</i>	00 <input type="checkbox"/> Parent 01 <input type="checkbox"/> Spouse 02 <input type="checkbox"/> Son/Daughter 03 <input type="checkbox"/> Son-in-law/Daughter-in-law 04 <input type="checkbox"/> Grandchild/Great grandchild 05 <input type="checkbox"/> Brother/Sister 06 <input type="checkbox"/> Brother-in-law/Sister-in-law 07 <input type="checkbox"/> Aunt/Uncle/Cousin 08 <input type="checkbox"/> Niece/Nephew 09 <input type="checkbox"/> Other relative 10 <input type="checkbox"/> Roommate/Friend/Neighbor 11 <input type="checkbox"/> Other non-relative	6-7
---	--	-----

b. How are you related to (sample person)? <i>If more than one proxy, direct this question to the one you consider to be the main proxy.</i>	00 <input type="checkbox"/> Parent 01 <input type="checkbox"/> Spouse 02 <input type="checkbox"/> Son/Daughter 03 <input type="checkbox"/> Son-in-law/Daughter-in-law 04 <input type="checkbox"/> Grandchild/Great grandchild 05 <input type="checkbox"/> Brother/Sister 06 <input type="checkbox"/> Brother-in-law/Sister-in-law 07 <input type="checkbox"/> Aunt/Uncle/Cousin 08 <input type="checkbox"/> Niece/Nephew 09 <input type="checkbox"/> Other relative 10 <input type="checkbox"/> Roommate/Friend/Neighbor 11 <input type="checkbox"/> Other non-relative	8-9
---	--	-----

ASK OR VERIFY: c. Do(es) [you/assistant] live here?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	10
---	--	----

<i>Mark each to indicate why a proxy/assistant was needed.</i>			
	Yes	No	
2a. Sample person hospitalized	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	11
b. Sample person institutionalized	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	12
c. Sample person's hearing problem	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	13
d. Sample person's speech problem	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	14
e. Sample person's language problem	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	15
f. Sample person's poor memory, senility, or confusion	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	16
g. Sample person's Alzheimer's disease	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	17
h. Sample person's other mental condition	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	18
i. Sample person's other physical illness and/or disability	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	19
j. Other non-health related reason	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	20

<i>The "respondent" in the following items refers to the sample person if he/she answered questions with or without assistance, or to the proxy if the sample person was not interviewed.</i>			
	Yes	No	
3. Do you feel the —			
a. Respondent was intellectually capable of responding?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
b. Respondent's answers were reasonably accurate?	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
c. Respondent understood the questions?	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>

Notes

Section N - INTERVIEWER OBSERVATIONS - Continued

<p>4a. Was there a section which seemed to be particularly upsetting or problematic to the respondent?</p>	<p>1 <input type="checkbox"/> Yes (<i>Go to 4b</i>) 2 <input type="checkbox"/> No (<i>Skip to 5</i>)</p>	<p>24</p>
<p>b. Which section(s)? Mark (X) all that apply.</p>	<p>01 <input type="checkbox"/> A. Housing and long-term care services 02 <input type="checkbox"/> B. Transportation 03 <input type="checkbox"/> C. Social activity 04 <input type="checkbox"/> D. Work history/employment 05 <input type="checkbox"/> E. Assistive devices and technologies 06 <input type="checkbox"/> F. Health insurance 07 <input type="checkbox"/> G. Assistance with key activities 08 <input type="checkbox"/> H. Other services 09 <input type="checkbox"/> I. Family structure, relationships, and living arrangements 10 <input type="checkbox"/> J. Conditions and impairments 11 <input type="checkbox"/> K. Health opinions and behaviors 12 <input type="checkbox"/> L. Community services 13 <input type="checkbox"/> M. Contact person</p>	<p>25-26 27-28 29-30 31-32 33-34 35-36 37-38 39-40 41-42 43-44 45-46 47-48 49-50</p>
<p>5. How tiring did the interview seem to be for the respondent?</p>	<p>1 <input type="checkbox"/> Very tiring 2 <input type="checkbox"/> A little tiring 3 <input type="checkbox"/> Not tiring</p>	<p>51</p>
<p>6. Did the respondent have difficulty hearing you during the interview?</p>	<p>1 <input type="checkbox"/> Yes (<i>Go to 7</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (<i>END interview</i>)</p>	<p>52</p>
<p>7. Do you feel the respondent's hearing difficulty affected the interview?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>53</p>

Notes

FORM **DFS-4**
(7-1-94)

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 AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

DISABILITY FOLLOWBACK SURVEY
(NHIS PHASE II)
POLIO SURVIVOR QUESTIONNAIRE

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 40 to 50 minutes per response, with an average of 45 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.

RT 70
3-7
8

RT 76
3-4

Part I - CALL RECORD

Mode	Date		Beginning time	Results	Ending time	Comments
	Month	Day				
5	6-7	8-9	10-14		15-19	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	
T P			a.m. p.m.		a.m. p.m.	

Notes

Part II - STATUS

A. Final Status

Interview

- 00 Never had polio
- 01 Complete
- 02 Partial (*Explain in notes*)

Noninterview

- 03 SP refused
- 04 Proxy refused
- 05 Unable to contact
- 06 Unable to locate
- 07 Deceased
- 08 Institutionalized, no proxy
- 09 Incapable, no proxy
- 10 Moved o/s PSU, unable to phone
- 11 Other noninterview

(Explain in notes)

5-6

C. Respondent

- 1 Self
- 2 Proxy

8

Reason for proxy

- 1 SP incapable
- 2 SP institutionalized
- 3 SP unavailable
- 4 Other - *Specify*

9

(Fill II.D)

D. Proxy

Name

B. Mode

- 1 Telephone
- 2 Personal visit

7

Relationship to SP

10-11

Part III - NEW ADDRESS

A. Address (*Different from label*)

Number and street

12-36

City

37-56

State

57-58

ZIP Code

59-67

B. Telephone (*Different from label*)

Area code

68-70

Number

71-77

1 None

9 DK number

78

7 Refused

Notes

POLIO SURVIVORS

5-7

Earlier, we were told that you had polio. The following questions deal with the time when you were first sick with polio, that is the first week or two of the illness.

1. How old were you when you got polio?

000 Less than 1 month

(Age) { 1 Months
2 Years

888 Never had polio (End Interview)
999 DK

2. In what year did you get polio?

8-9

1 9 Year

99 DK

3. In what month of the year did this illness start?

10-11

Enter number in 2-digit numerals: 01-January through 12-December.

Month

99 DK

**ITEM
P1**

Refer to question 1 above:
(Age when respondent got polio.)

12

1 Less than 5 years old (Read intro to question 4)
2 Five years or more (Ask question 4 without intro)
9 DK (Read intro to question 4)

I'm going to ask some questions about the first two weeks of your illness. Because you may have been too young to remember much, just answer the best you can based on what your parents or other family members and friends told you.

4. During the first two weeks you had polio, did you experience —

Yes No DK

a. Fever?

a. 1 2 9

13

b. Headache?

b. 1 2 9

14

c. Stiff neck?

c. 1 2 9

15

d. Diarrhea?

d. 1 2 9

16

e. Muscle pains?

e. 1 2 9

17

f. Skin rash?

f. 1 2 9

18

Notes

POLIO SURVIVORS - Continued

<p>5. During the first month you had polio, did you experience WEAKNESS in the following parts of your body —</p> <p>a. Right arm or hand?</p> <p>b. Left arm or hand?</p> <p>c. Right leg or foot?</p> <p>d. Left leg or foot?</p> <p>e. Swallowing muscles?</p> <p>f. Face muscles?</p> <p>g. Neck muscles?</p> <p>h. Breathing muscles?</p> <p>i. Back or stomach muscles?</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>DK</th> <th></th> </tr> </thead> <tbody> <tr> <td>a.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">19</td> </tr> <tr> <td>b.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">20</td> </tr> <tr> <td>c.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">21</td> </tr> <tr> <td>d.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">22</td> </tr> <tr> <td>e.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">23</td> </tr> <tr> <td>f.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">24</td> </tr> <tr> <td>g.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">25</td> </tr> <tr> <td>h.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">26</td> </tr> <tr> <td>i.</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td align="right">27</td> </tr> </tbody> </table>		Yes	No	DK		a.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	19	b.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	20	c.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	21	d.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	22	e.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	23	f.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	24	g.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	25	h.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	26	i.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	27
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<p>6. During the first month of your illness, did you have any difficulty passing urine?</p>	<table border="0"> <tbody> <tr> <td>1 <input type="checkbox"/> Yes</td> <td></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td align="right">28</td> </tr> </tbody> </table>	1 <input type="checkbox"/> Yes		2 <input type="checkbox"/> No		9 <input type="checkbox"/> DK	28																																												
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<p>7. Were you admitted to a hospital at the time you were first diagnosed with polio?</p>	<table border="0"> <tbody> <tr> <td>1 <input type="checkbox"/> Yes (Go to 8)</td> <td></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td rowspan="2">} (Skip to 9)</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </tbody> </table>	1 <input type="checkbox"/> Yes (Go to 8)		2 <input type="checkbox"/> No	} (Skip to 9)	9 <input type="checkbox"/> DK																																													
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<p>8. Did you receive a spinal tap at the time you were diagnosed with polio?</p>	<table border="0"> <tbody> <tr> <td>1 <input type="checkbox"/> Yes</td> <td></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td align="right">30</td> </tr> </tbody> </table>	1 <input type="checkbox"/> Yes		2 <input type="checkbox"/> No		9 <input type="checkbox"/> DK	30																																												
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<p>9. At the time you were diagnosed with polio, did you experience problems with breathing?</p>	<table border="0"> <tbody> <tr> <td>1 <input type="checkbox"/> Yes (Go to 10)</td> <td></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td rowspan="2">} (Skip to 12 on page 5)</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </tbody> </table>	1 <input type="checkbox"/> Yes (Go to 10)		2 <input type="checkbox"/> No	} (Skip to 12 on page 5)	9 <input type="checkbox"/> DK																																													
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<p>10. Did you require help with breathing?</p>	<table border="0"> <tbody> <tr> <td>1 <input type="checkbox"/> Yes (Go to 11)</td> <td></td> </tr> <tr> <td>2 <input type="checkbox"/> No</td> <td rowspan="2">} (Skip to 12 on page 5)</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> </tr> </tbody> </table>	1 <input type="checkbox"/> Yes (Go to 11)		2 <input type="checkbox"/> No	} (Skip to 12 on page 5)	9 <input type="checkbox"/> DK																																													
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<p>11. What kind of help did you need?</p> <p><i>Mark (X) all that apply.</i></p>	<table border="0"> <tbody> <tr> <td>1 <input type="checkbox"/> Occasional assistance with a hand held device</td> <td align="right">33</td> </tr> <tr> <td>2 <input type="checkbox"/> Mechanical ventilation (iron lung or respirator)</td> <td align="right">34</td> </tr> <tr> <td>3 <input type="checkbox"/> Something else - <i>Specify</i> <input checked="" type="checkbox"/></td> <td align="right">35</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td>9 <input type="checkbox"/> DK</td> <td align="right">36</td> </tr> </tbody> </table>	1 <input type="checkbox"/> Occasional assistance with a hand held device	33	2 <input type="checkbox"/> Mechanical ventilation (iron lung or respirator)	34	3 <input type="checkbox"/> Something else - <i>Specify</i> <input checked="" type="checkbox"/>	35	_____		_____		9 <input type="checkbox"/> DK	36																																						
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POLIO SURVIVORS - Continued

12a. Beginning about one month after you got polio, did you go through a period of rehabilitation? This would include a time when you might have had physical therapy, doctor's checkups, and/or surgical procedures to help you recover from polio.

- 1 Yes (Go to 12b)
 2 No } (Skip to 20 on page 8)
 9 DK }

37

b. About how long would you say this period of rehabilitation lasted?

- 000 Less than 1 month
 _____ }
 (Number) 1 Months
 2 Years
 999 DK

38-40

HAND CARD P1.

The next few questions deal with this period of REHABILITATION.

13. Beginning approximately two months after you got polio, that is, after the initial phase of your illness had passed:

	Not weakened	Mildly weakened	Moderately weakened	Severely weakened	Completely paralyzed	DK
a. How weakened was your right hip, thigh and knee? Would you say — (Read all categories)?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
b. How weakened was your right calf, ankle and foot? (Would you say — (Read all categories)?)	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
c. How weakened was your left hip, thigh and knee? (Would you say — (Read all categories)?)	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
d. How weakened was your left calf, ankle and foot? (Would you say — (Read all categories)?)	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
e. How weakened was your right shoulder, upper arm and elbow? (Would you say — (Read all categories)?)	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
f. How weakened was your right forearm, wrist and hand? (Would you say — (Read all categories)?)	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
g. How weakened was your left shoulder, upper arm and elbow? (Would you say — (Read all categories)?)	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
h. How weakened was your left forearm, wrist and hand? (Would you say — (Read all categories)?)	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
i. How weakened were your breathing muscles? (Would you say — (Read all categories)?)	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
j. How weakened were your swallowing muscles? (Would you say — (Read all categories)?)	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
k. How weakened were your face muscles? (Would you say — (Read all categories)?)	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
l. How weakened were your back muscles? (Would you say — (Read all categories)?)	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
m. How weakened were your stomach muscles? (Would you say — (Read all categories)?)	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>

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POLIO SURVIVORS - Continued

ITEM P2	<p><i>Refer to question 1 on page 3. (Age when respondent got polio)</i></p>	<div style="text-align: right; border: 1px solid black; padding: 2px;">54</div> <p>1 <input type="checkbox"/> Less than 12 months old <i>(Skip to 18 on page 7)</i> 2 <input type="checkbox"/> 12 months or older <i>(Go to 14)</i> 3 <input type="checkbox"/> DK <i>(Go to 14)</i></p>
<p><i>HAND CARD P2.</i></p> <p>14. Beginning approximately two months after you got polio, how well could you walk? Would you say you were — <u>(Read all categories)</u></p>		<div style="text-align: right; border: 1px solid black; padding: 2px;">55</div> <p>1 <input type="checkbox"/> Able to walk without a limp, 2 <input type="checkbox"/> Able to walk WITH a limp, 3 <input type="checkbox"/> Unable to walk WITHOUT leg braces or other assistive devices, or 4 <input type="checkbox"/> Unable to walk at all? 5 <input type="checkbox"/> Can't remember 9 <input type="checkbox"/> DK</p>
<p><i>HAND CARD P3. Read categories if telephone interview.</i></p> <p>15. During your rehabilitation, what kind of physical therapy or exercise did you use to strengthen your muscles?</p> <p>(Anything else?)</p> <p><i>Mark (X) all that apply.</i></p>		<div style="text-align: right; border: 1px solid black; padding: 2px;">56-57</div> <p>00 <input type="checkbox"/> No exercise or physical therapy <i>(Skip to 20 on page 8)</i></p> <p>01 <input type="checkbox"/> Stretching exercises 58-59</p> <p>02 <input type="checkbox"/> Massage/heat 60-61</p> <p>03 <input type="checkbox"/> Yoga 62-63</p> <p>04 <input type="checkbox"/> Swimming 64-65</p> <p>05 <input type="checkbox"/> Weight lifting/medicine ball 66-67</p> <p>06 <input type="checkbox"/> Push-ups/pull-ups 68-69</p> <p>07 <input type="checkbox"/> Other - <i>Specify</i> <u> </u> 70-71</p> <p style="text-align: right;">} <i>(Go to 16)</i></p> <p>08 <input type="checkbox"/> Too young to remember 72-73</p> <p>99 <input type="checkbox"/> DK <i>(Skip to 20 on page 8)</i> 74-75</p>
<p>16. During your rehabilitation, how often did you do physical therapy or exercise to stretch or strengthen your muscles? Would you say — regularly or only occasionally, such as less than twice a month?</p>		<div style="text-align: right; border: 1px solid black; padding: 2px;">76</div> <p>1 <input type="checkbox"/> Regularly } <i>(Go to 17)</i> 2 <input type="checkbox"/> Occasionally } 9 <input type="checkbox"/> DK <i>(Skip to 20 on page 8)</i></p>
<p>17. For how many years did you continue your physical therapy or exercise schedule?</p>		<div style="text-align: right; border: 1px solid black; padding: 2px;">77-78</div> <p>00 <input type="checkbox"/> Less than 1 year</p> <p>_____ Years (Number)</p> <p>99 <input type="checkbox"/> DK</p>
<p>Notes</p>		

POLIO SURVIVORS - Continued

18. During your rehabilitation, did you have surgery on your arms, legs, or spine which was intended to correct a limitation or weakness caused by polio?

- 1 Yes (Go to 19)
2 No } (Skip to 20 on page 8)
9 DK }

79

19. Please tell me each surgical procedure you had and your age at the time of the procedure?

Any others?

Enter age in whole years. If less than 1 year old, enter "00".

Enter a description of the procedure if the exact name is not known

Age 99 DK age
(Years)

80-81

Surgical procedure description

82-83

99 DK surgical procedure

Age 99 DK age
(Years)

84-85

Surgical procedure description

86-87

99 DK surgical procedure

Age 99 DK age
(Years)

88-89

Surgical procedure description

90-91

99 DK surgical procedure

Notes

POLIO SURVIVORS - Continued

92-95

20. For the next few questions, please think about the period when you were at your **PHYSICAL BEST after having polio. By **physical best** we mean the period when you had the greatest strength and endurance and were in the best condition to carry on the various activities of daily living such as working, housework, walking, driving, dressing, bathing, and so forth.**

After having polio, at what age, or between what ages, were you at your physical best?

Enter age(s) in whole years or mark (X) box.

to Years of age } (Go to 21)

- 9977 Presently at physical best
- 9988 Never had a physical best } (Skip to 41 on page 15)
- 9999 DK

HAND CARD P4.

96

21. During the period of your **physical best AFTER THE ONSET OF POLIO, which phrase best describes the extent of your disability? Would you say — (Read all categories)**

Mark (X) only one.

- 1 No disability, (Skip to 29 on page 10)
- 2 No noticeable disability,
- 3 Mild disability,
- 4 Moderate disability, or
- 5 Severe disability? } (Go to 22)
- 9 DK

HAND CARD P2.

97

22. During the period of your **physical best after the onset of polio, how well could you walk?**

*If telephone interview, read: **Would you say you were — (Read all categories)***

Mark (X) only one.

- 1 Able to walk without a limp } (Go to 23)
- 2 Able to walk WITH a limp
- 3 Unable to walk WITHOUT leg braces or other assistive devices (Skip to 24)
- 4 Unable to walk at all (Skip to 26 on page 9)
- 5 Can't remember } (Go to 23)
- 9 DK

HAND CARD P5.

98

23. During the period of your **physical best after the onset of your polio, what was the farthest you could walk WITHOUT using assistive devices and WITHOUT stopping?**

*If telephone interview, read: **Would you say you — (Read all categories)***

Mark (X) only one.

- 1 Couldn't walk at all } (Go to 24)
- 2 Could walk across a room
- 3 Could walk up and down the street
- 4 Could walk around the block
- 5 Could walk a mile or more (Skip to 25 on page 9)
- 9 DK (Go to 24)

HAND CARD P5.

99

24. How about WITH a leg brace or assistive devices such as a cane or walker? What was the farthest you could walk WITHOUT stopping during the period of your physical best?

*If telephone interview, read: **Would you say that you — (Read all categories)***

Mark (X) only one.

- 1 Couldn't walk at all (Skip to 26)
- 2 Could walk across a room
- 3 Could walk up and down the street
- 4 Could walk around the block
- 5 Could walk a mile or more } (Go to 25 on page 9)
- 9 DK

POLIO SURVIVORS - Continued

25. During the period of your physical best after the onset of your polio, how well could you climb stairs? Would you say you — (Read all categories)

Mark (X) only one.

- 1 Could climb stairs easily without using a railing,
- 2 Could climb stairs using a railing, or
- 3 Could not climb stairs at all?
- 9 DK

5

26. During the period of your physical best after the onset of your polio, how easily would you tire while performing your usual daily activities? Would you say you — (Read all categories)

Mark (X) only one.

- 1 Tired VERY easily during the day, requiring five or more rest periods,
- 2 Tired easily during the day, requiring two to four rest periods,
- 3 Tired slowly and required one rest period a day, or
- 4 Tired only after strenuous exercise or before bedtime?
- 9 DK

6

27. I am going to read a list of assistive devices. Please tell me if you used each device at any time during your period of physical best.

Read list.

Mark (X) an answer for each type of device.

Yes No DK

a. A cane or canes?

a. 1 2 9

7

b. A crutch or crutches?

b. 1 2 9

8

c. Walker?

c. 1 2 9

9

d. Wheel chair or electric cart?

d. 1 2 9

10

e. Left leg brace?

e. 1 2 9

11

f. Right leg brace?

f. 1 2 9

12

g. Left arm splint or brace?

g. 1 2 9

13

h. Left hand splint or brace?

h. 1 2 9

14

i. Right arm splint or brace?

i. 1 2 9

15

j. Right hand splint or brace?

j. 1 2 9

16

k. Breathing aids?

k. 1 2 9

17

l. Back brace or corset?

l. 1 2 9

18

m. Special shoes, or shoe lifts?

m. 1 2 9

19

n. Another type of device?

n. 1 2 9

20

Specify _____

POLIO SURVIVORS - Continued

<i>HAND CARD P1.</i>	Not weakened	Mildly weakened	Moder- ately weakened	Severely weakened	Com- pletely paralyzed	DK
28. At the time of your physical best:						21
a. How weakened was your right hip, thigh and knee? Would you say — (Read all categories)?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
b. How weakened was your right calf, ankle and foot? (Would you say — (Read all categories)?)	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
c. How weakened was your left hip, thigh and knee? (Would you say — (Read all categories)?)	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
d. How weakened was your left calf, ankle and foot? (Would you say — (Read all categories)?)	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
e. How weakened was your right shoulder, upper arm and elbow? (Would you say — (Read all categories)?)	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
f. How weakened was your right forearm, wrist and hand? (Would you say — (Read all categories)?)	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
g. How weakened was your left shoulder, upper arm and elbow? (Would you say — (Read all categories)?)	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
h. How weakened is your left forearm, wrist and hand? (Would you say — (Read all categories)?)	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
i. How weakened were your breathing muscles? (Would you say — (Read all categories)?)	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
j. How weakened were your swallowing muscles? (Would you say — (Read all categories)?)	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
k. How weakened were your face muscles? (Would you say — (Read all categories)?)	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
l. How weakened were your back muscles? (Would you say — (Read all categories)?)	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
m. How weakened were your stomach muscles? (Would you say — (Read all categories)?)	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
29. About how much did you weigh during the time of your physical best? <i>Enter weight in whole pounds only.</i>	_____ Pounds					34-36
	999 <input type="checkbox"/> DK					
Now I am going to ask some questions about the period AFTER your physical best.						37
30. At the present time, do you feel you are STILL at your physical best?	1 <input type="checkbox"/> Yes (Skip to 41 on page 15) 2 <input type="checkbox"/> No } (Go to 31 on page 11) 9 <input type="checkbox"/> DK }					
Notes						

POLIO SURVIVORS - Continued

<p>31. Since the period when you were at your physical best have you experienced any DECREASE in your ability to carry out your routine activities of daily living such as working, housework, walking, driving, dressing, bathing, and so forth?</p> <p><i>If "Yes," ask: Would you say that your ability has decreased some or a lot?</i></p>	<p align="right">38</p> <p>1 <input type="checkbox"/> Yes, decreased some 2 <input type="checkbox"/> Yes, decreased a lot 3 <input type="checkbox"/> No, no decrease 9 <input type="checkbox"/> DK</p>
<p>32. Since the time of your physical best, do you NOW weigh more, less, or about the same?</p>	<p align="right">39</p> <p>1 <input type="checkbox"/> More } (Go to 33) 2 <input type="checkbox"/> Less } 3 <input type="checkbox"/> About the same } (Skip to 34) 9 <input type="checkbox"/> DK</p>
<p>33. How many pounds have you [gained/lost]?</p> <p><i>Enter gain or loss in whole pounds only.</i></p>	<p align="right">40-42</p> <p>_____ Pounds</p> <p>999 <input type="checkbox"/> DK</p>
<p>34. Since the time of your physical best, have you had any severe injuries which have limited your ability to carry out your daily activities?</p>	<p align="right">43</p> <p>1 <input type="checkbox"/> Yes (Go to 35) 2 <input type="checkbox"/> No } (Skip to 36) 9 <input type="checkbox"/> DK }</p>
<p>35. What were the injuries and how old were you when they occurred?</p> <p>Any others?</p> <p><i>Enter age in whole years.</i></p> <p><i>Describe the injury, NOT the accident.</i></p> <p><i>(Example: Enter "Broken hip" not "fell")</i></p>	<p align="right">44-45</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>
	<p align="right">46-48</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>
	<p align="right">49-50</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>
	<p align="right">51-53</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>
	<p align="right">54-55</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>
	<p align="right">56-58</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>
<p align="right">59-60</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>	
<p align="right">61-63</p> <p><input type="text"/> <input type="text"/> Age 99 <input type="checkbox"/> DK age (Years)</p> <p>Injury <u> </u></p> <p>799 <input type="checkbox"/> DK injury</p>	
<p>36. Compared with your physical best, has your ability to swallow solid food gotten better, gotten worse, or stayed about the same?</p>	<p align="right">64</p> <p>1 <input type="checkbox"/> Gotten better 2 <input type="checkbox"/> Gotten worse 3 <input type="checkbox"/> Stayed about the same 9 <input type="checkbox"/> DK</p>

POLIO SURVIVORS - Continued

<p>37. Since reaching your physical best, have you experienced any NEW polio related difficulties?</p> <p><i>If "Yes", ask: How many new polio-related difficulties have you experienced?</i></p> <p><i>Mark (X) only one.</i></p>	<p>1 <input type="checkbox"/> Yes, one new polio-related difficulty</p> <p>2 <input type="checkbox"/> Yes, more than one new polio-related difficulty</p> <p>3 <input type="checkbox"/> New difficulties, BUT not sure they are polio-related</p> <p>4 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <p align="right">} (Go to 38)</p> <p align="right">} (Skip to 41 on page 15)</p>	65
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<p>38. How old were you when [this/your MAIN] new polio-related difficulty began?</p> <p><i>Enter age in whole years only.</i></p>	<p>_____ Years of age</p> <p>99 <input type="checkbox"/> DK</p>	66-67
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<p>39. About how quickly did [this/your MAIN] new polio-related difficulty develop? Was it over a period of — (Read all categories)</p> <p><i>Mark (X) only one.</i></p>	<p>1 <input type="checkbox"/> Less than one month,</p> <p>2 <input type="checkbox"/> One month, but less than a year,</p> <p>3 <input type="checkbox"/> One year, but less than 5 years,</p> <p>4 <input type="checkbox"/> 5 years, but less than 10 years, or</p> <p>5 <input type="checkbox"/> 10 or more years?</p> <p>6 <input type="checkbox"/> Other – Specify _____</p> <p>9 <input type="checkbox"/> DK</p>	68
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<p>40a. Compared with your physical best, have you experienced any NEW muscle WEAKNESS?</p>	<p>1 <input type="checkbox"/> Yes (Go to 40b)</p> <p>2 <input type="checkbox"/> No</p> <p>9 <input type="checkbox"/> DK</p> <p align="right">} (Skip to 40c)</p>	69
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HAND CARD P6.

b. Which of the following muscles are involved?

	Yes	No	DK	
(1) Left arm or hand?	(1) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	70
(2) Right arm or hand?	(2) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	71
(3) Left leg or foot?	(3) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	72
(4) Right leg or foot?	(4) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	73
(5) Stomach, back or torso?	(5) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	74
(6) Neck or face?	(6) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	75

<p>Notes</p>	
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POLIO SURVIVORS - Continued

40c. Compared with your physical best, have you experienced any NEW muscle PAIN?

- 1 Yes (Go to 40d)
 2 No } (Skip to 40e)
 9 DK }

76

HAND CARD P6.

d. Which of the following muscles are involved?

Yes No DK

(1) Left arm or hand? (1) 1 2 9

77

(2) Right arm or hand? (2) 1 2 9

78

(3) Left leg or foot? (3) 1 2 9

79

(4) Right leg or foot? (4) 1 2 9

80

(5) Stomach, back or torso? (5) 1 2 9

81

(6) Neck or face? (6) 1 2 9

82

e. Compared with your physical best, have you experienced any NEW JOINT pains?

- 1 Yes (Go to 40f)
 2 No } (Skip to 40g)
 9 DK }

83

HAND CARD P7.

f. Which of the following joints are involved?

Yes No DK

(1) Left shoulder, elbow, or wrist? (1) 1 2 9

84

(2) Right shoulder, elbow, or wrist? (2) 1 2 9

85

(3) Left hip, knee, or ankle? (3) 1 2 9

86

(4) Right hip, knee, or ankle? (4) 1 2 9

87

(5) Neck or spine? (5) 1 2 9

88

Notes

POLIO SURVIVORS - Continued

40g. Compared with your physical best, have you noticed any change in the size of muscles FORMERLY WEAKENED by polio?

- 1 Yes (Go to 40h)
 2 No } (Skip to 41 on page 15)
 9 DK }

89

h. Have the muscles increased or decreased in size?

Mark (X) only one.

- 1 Increased in size
 2 Decreased in size
 3 Some increased/some decreased
 9 DK

90

HAND CARD P6.

i. Which of the following muscles are involved?

- | | Yes | No | DK | |
|--|--------------------------------|----------------------------|----------------------------|----|
| (1) Left arm or hand? | (1) 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 91 |
| (2) Right arm or hand? | (2) 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 92 |
| (3) Left leg or foot? | (3) 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 93 |
| (4) Right leg or foot? | (4) 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 94 |
| (5) Stomach, back or torso? | (5) 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 95 |
| (6) Neck or face? | (6) 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 9 <input type="checkbox"/> | 96 |

Notes

POLIO SURVIVORS - Continued

HAND CARD P1.

The following questions deal with the **PRESENT TIME** that is, over the past few weeks.

41. At the present time,

a. How weakened is your right hip, thigh and knee? Would you say — (Read all categories)?

Not weakened	Mildly weakened	Moderately weakened	Severely weakened	Completely paralyzed	DK
--------------	-----------------	---------------------	-------------------	----------------------	----

a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

b. How weakened is your right calf, ankle and foot? (Would you say — (Read all categories)?)

b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

c. How weakened is your left hip, thigh and knee? (Would you say — (Read all categories)?)

c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

d. How weakened is your left calf, ankle and foot? (Would you say — (Read all categories)?)

d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

e. How weakened is your right shoulder, upper arm and elbow? (Would you say — (Read all categories)?)

e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

f. How weakened is your right forearm, wrist and hand? (Would you say — (Read all categories)?)

f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

g. How weakened is your left shoulder, upper arm and elbow? (Would you say — (Read all categories)?)

g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

h. How weakened is your left forearm, wrist and hand? (Would you say — (Read all categories)?)

h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

i. How weakened are your breathing muscles? (Would you say — (Read all categories)?)

i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

j. How weakened are your swallowing muscles? (Would you say — (Read all categories)?)

j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

k. How weakened are your face muscles? (Would you say — (Read all categories)?)

k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

l. How weakened are your back muscles? (Would you say — (Read all categories)?)

l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
-------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

m. How weakened are your stomach muscles? (Would you say — (Read all categories)?)

m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
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HAND CARD P8.

42. At the present time, what is the farthest you can walk WITHOUT using assistive devices and WITHOUT stopping? Would you say you — (Read all categories)

- 1 Cannot walk at all,
- 2 Can walk across a room,
- 3 Can walk up and down the street,
- 4 Can walk around the block, or
- 5 Can walk a mile or more?
- 9 DK

43. At the present time, how well can you climb stairs? Would you say you — (Read all categories)

- 1 Can climb stairs easily without using a railing,
- 2 Can climb stairs with a railing, or
- 3 Cannot climb stairs at all?
- 9 DK

POLIO SURVIVORS – Continued

44. Do you NOW use any of the following assistive devices?

Mark (X) an answer for each type of device.

Read list.

	Yes	No	DK	
a. A cane or canes?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	20
b. A crutch or crutches?	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	21
c. Walker?	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	22
d. Wheel chair or electric cart?	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	23
e. Left leg brace?	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	24
f. Right leg brace?	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	25
g. Left arm splint or brace?	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	26
h. Left hand splint or brace?	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	27
i. Right arm splint or brace?	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	28
j. Right hand splint or brace?	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	29
k. Breathing aids?	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	30
l. Back brace or corset?	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	31
m. Special shoes, or shoe lifts?	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	32
n. Another type of device?	n. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	33

Specify _____

45. During the past few weeks, how easily did you tire while performing your usual daily activities? Would you say you — (Read all categories)

Mark (X) only one.

- 34
- 1 Tire **VERY** easily during the day, requiring five or more rest periods in the day,
 - 2 Tire easily during the day, requiring two to four rest periods,
 - 3 Tire slowly and require one rest period a day, or
 - 4 Tire only after strenuous exercise or before bedtime?
 - 9 DK

Notes

POLIO SURVIVORS - Continued

46. At present, do you feel your general health is improving, declining, or staying about the same?

- 1 Improving *(Skip to 50 on page 18)*
- 2 Declining *(Go to 47)*
- 3 About the same } *(Skip to 50 on page 18)*
- 9 DK

35

47. What do you think is the main cause of this decline?

Mark (X) only one.

- 1 Aging
- 2 Sedentary lifestyle
- 3 Return of old problems/conditions
- 4 New chronic conditions
- 5 Other new illness
- 6 Late effects of polio *(Go to 48)*
- 7 Other } *(Skip to 50 on page 18)*
- 9 DK

36

Mark (X) box "0" or ask.

HAND CARD P9. Read categories if telephone interview.

48. Which statement best describes how you feel about your physical condition?

- 0 Proxy *(Skip to 50 on page 18)*
- 1 I do not feel disabled
- 2 I feel disabled for the first time in my life
- 3 Now I feel like I have a second disability
- 4 None of the above
- 9 DK

37

49. To what extent do you feel that your earlier experience with polio has prepared you to deal with this decline? Would you say —
(Read all categories)

- 1 **Not at all,**
- 2 **Somewhat, or**
- 3 **A lot?**
- 9 DK

38

Notes

POLIO SURVIVORS - Continued

50. Now I want to ask some questions about other health problems.

Read each condition and mark (X) box. Then proceed to question 51.

Has a doctor ever told you that you had —

Ask for each condition marked "Yes" in 50.

51. Are you currently taking medication for your (condition)?

	Yes	No	DK	Yes	No	DK
			39			40
a. Diabetes?	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	a. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			41			42
b. Emphysema?	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	b. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			43			44
c. Chronic bronchitis?	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	c. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			45			46
d. Asthma?	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	d. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			47			48
e. Heart problems?	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	e. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			49			50
f. Circulation problems in your arms or legs?	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	f. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			51			52
g. Hypertension?	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	g. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			53			54
h. A stroke?	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	h. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			55			56
i. Stomach ulcers?	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	i. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			57			58
j. Gallbladder problems?	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	j. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			59			60
k. Urinary tract problems?	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	k. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			61			62
l. Kidney stones?	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	l. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			63			64
m. Arthritis?	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	m. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			65			66
n. Other joint problems?	n. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	n. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			67			68
o. Cancer or leukemia?	o. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	o. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			69			70
p. A nerve or muscle disorder other than polio?	p. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	p. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			71			72
q. A sleep disorder?	q. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	q. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
			73			74
r. (Males only) Prostate problems?	r. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>	r. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>

POLIO SURVIVORS - Continued

52. Has a doctor ever told you that you are suffering from post-polio syndrome?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	75
53. Post-polio syndrome is NEW weakness, NEW pain or NEW tiredness in people who previously had polio. Do YOU think you have post-polio syndrome?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	76
If proxy interview, skip to 56, otherwise, read the appropriate statement. If personal visit, HAND CARD P10 and read: Please read the statements on this card. If telephone interview, read: Now, I am going to read some statements.		
54. For each one, please tell me whether it is not true, somewhat true, or very true for you.	Not true Somewhat true Very true DK	
a. I've always felt that I could make of my life pretty much what I wanted to make of it. Is that not true, somewhat true, or very true for you?	a. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	77
b. Once I make up my mind to do something, I stay with it until the job is completely done. (Is that not true, somewhat true, or very true for you?)	b. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	78
c. I don't let my personal feelings get in the way of getting a job done. (Is that not true, somewhat true, or very true for you?)	c. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	79
d. It's important for me to be able to do things in the way I want to do them rather than in the way other people want me to do them. (Is that not true, somewhat true, or very true for you?)	d. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	80
e. Sometimes I feel that if anything is going to be done right, I have to do it myself. (Is that not true, somewhat true, or very true for you?)	e. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	81
f. I like doing things that other people thought could not be done. (Is that not true, somewhat true, or very true for you?)	f. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	82
g. I feel like I am the kind of person who stands for what she/he believes in, regardless of the consequences. (Is that not true, somewhat true, or very true for you?)	g. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	83
h. Hard work is the best possible way for a young person to get ahead in life. (Is that not true, somewhat true, or very true for you?)	h. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	84
i. People have made fun of me because of the physical effects of polio. (Is that not true, somewhat true, or very true for you?)	i. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	85
j. I have been discriminated against because of the physical effects of polio. (Is that not true, somewhat true, or very true for you?)	j. 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/>	86
55. On a scale from 1 to 7, with 1 being VERY SATISFIED and 7 being VERY UNSATISFIED, how satisfied or unsatisfied are you with your life as a whole these days? Repeat if necessary. Mark (X) only one.	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> Very satisfied → Very unsatisfied	87

POLIO SURVIVORS - Continued

ITEM P3	<p><i>Refer to other DFS questionnaires for this sample person.</i></p>	<p>1 <input type="checkbox"/> Any DFS 1, 2, or 3 completed (<i>Skip to 58a on page 21</i>)</p> <p>2 <input type="checkbox"/> None completed (<i>Go to Intro</i>)</p>	88
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INTRO **The National Center for Health Statistics may wish to contact you again to obtain additional health related information.**

ITEM P4	<p><i>Refer to CP on label.</i></p>	<p>1 <input type="checkbox"/> CP on label (<i>Ask 56a</i>)</p> <p>2 <input type="checkbox"/> No CP on label (<i>Ask 56b</i>)</p>	89
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<p>56a. The last time a Census Bureau interviewer talked to you or your family, we were told that <u>(CP on label)</u> will always know how to get in touch with you if we want to contact you again. Is <u>(CP on label)</u> still the best person to contact if we are unable to reach you?</p>	<p>1 <input type="checkbox"/> Yes (<i>Verify CP's address and phone number. If incorrect, enter correct information in 57 below</i>)</p> <p>2 <input type="checkbox"/> No (<i>Go to 56b</i>)</p>	90
<p>b. The National Center for Health Statistics would like the name, address, and telephone number of a relative or friend who would know where you could be reached in case we need additional health information in the future but cannot reach you. Please give me the name of someone who is not currently living in the household.</p> <p><i>(Record information in 57)</i></p>	<div style="border: 1px dashed black; height: 100px;"></div>	RT 81

57. Contact person current information

Last name	3-4 5-24	First name	25-39	Middle initial	40
Address (<i>Number and street</i>)					41-65
City	66-85	State	86-87	ZIP Code	88-96
Telephone:	Area code	97-99	Number	100-106	107
					1 <input type="checkbox"/> None 7 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK

Notes

POLIO SURVIVORS - Continued

READ: The last few questions deal with locating medical records.

5

58a. The physicians who designed this questionnaire have a special interest in post-polio syndrome and would like to review the past medical records of as many polio survivors as possible. Could we have your permission to get copies of your medical records?

- 1 Yes (Go to 58b)
- 2 No (END INTERVIEW)
- 9 DK (Go to 58b)

b. What is the name and address of the hospital to which you were first admitted when you got polio?

6

- 0 None (Go to 58c)
- 1 Name of hospital/facility

Address (Number and street)		
City/Town	State	ZIP Code

- 9 DK

c. What are the names and addresses of any other hospitals or medical facilities to which you were admitted for rehabilitation or surgery related to your illness?

Any other?

7

- 0 None (Go to 59)
- 1 Name of hospital/facility

Address (Number and street)		
City/Town	State	ZIP Code

- 9 DK

- 0 None (Go to 59)
- 1 Name of hospital/facility

8

Address (Number and street)		
City/Town	State	ZIP Code

- 9 DK

59a. Are there additional persons, physicians, physical therapists, and so forth, who may have records of your polio illness?

9

- 1 Yes (Go to 59b on page 22)
 - 2 No
 - 9 DK
- } (Skip to Item P5a on page 22)

POLIO SURVIVORS - Continued

59b. What are their names and addresses?

10

Any other?

- 0 None
 1 Name

Address (Number and street)		
City/Town	State	ZIP Code
Telephone number	Area code ()	Number

- 0 None
 1 Name

11

Address (Number and street)		
City/Town	State	ZIP Code
Telephone number	Area code ()	Number

- 0 None
 1 Name

12

Address (Number and street)		
City/Town	State	ZIP Code
Telephone number	Area code ()	Number

13

**ITEM
P5a**

Mode of interview

- 1 Telephone
 2 Personal visit

**ITEM
P5b**

Respondent status

- 1 Adult self response (Go to 60)
 2 Adult - Proxy (END INTERVIEW)

14

60. So that we might obtain your records, will you sign a form consenting to the release of records relating to your polio illness? Your confidentiality will be carefully safeguarded and no personal information will be made available at any time.

- 1 Yes (Provide form on page 23 for signature. If telephone interview, mail page 23 to respondent for signature)
 2 No (END INTERVIEW)

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