

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).

1. RO 9-10 2. Sample 11-13 Suffix 14 3. Week 15-16 4. Segment type 1 Area 2 Permit 5. Control number PSU Segment Suffix Serial Suffix Check digit 6. Screening status 1 S 2 I 32

HIS-1 (1996) U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE NATIONAL HEALTH INTERVIEW SURVEY

7a. What is your exact address? (Including House No., Apt. No., or other identification; county and ZIP Code) 4-8 LISTING SHEET 9-119 City State County ZIP Code

15. Neighbor screening results (Mark if "S" in item 6) 55 0 Neighbors not contacted 1 Screened out by neighbors 2 Eligible per neighbor 3 Undetermined by neighbors

b. Is this your mailing address? (Mark box or specify if different; include county and ZIP Code) RT 12 4-83 Same as 7a City State County ZIP Code c. GQ name 84-117 Sample unit No. Type code 118-120

16. Noninterview reason TYPE A 56-57 58 01 Refused 02 No one home, repeated calls 03 Temporarily absent 04 Language problem 05 Other (Specify) Indicate best estimate of race/ethnicity for each Type A 1 Black/Hispanic 2 Not Black/Hispanic 3 Unknown Fill items 1-7a, 8 and 10 as applicable; 11, 13-17.

8. YEAR BUILT (Area segments only) Ask (Except for group quarters, mobile homes, trailers, tents, boats, and other units not in structures.) Do not ask When was this structure originally built? Before 4-1-90 (Continue interview) After 4-1-90 (Complete 9c when required; END interview)

TYPE B 06 Vacant, nonseasonal 07 Vacant, seasonal 08 Occupied entirely by URE 09 Occupied entirely by AF members 10 Occupied - screened out by household 11 Occupied - screened out by neighbors 12 Unfit or to be demolished 13 Under construction - not ready 14 Converted to temporary business or storage 15 Unoccupied site for mobile home, trailer, or tent 16 Permit granted - construction not started 17 Other (Specify) TYPE C 18 Unused line of listing sheet 19 Demolished 20 House or trailer moved 21 Outside segment boundaries 22 Converted to permanent business or storage 23 Merged 24 Condemned 25 Built after April 1, 1990 26 Other (Specify) Fill items 1-7a, 8-10 as applicable; 11, 13-17. Fill items 1-7a, 9c if marked; 13-17, send Inter-Comm.

9. COVERAGE QUESTIONS Ask items that are marked Do not ask a. Are there any other living quarters - either occupied or vacant - in this building? b. Are there any other living quarters - either occupied or vacant - on this floor? c. Is there any other building, mobile home, or trailer - either occupied or vacant - on this property for people to live in?

10a. LAND USE RT 10 33 1 URBAN (11) 2 RURAL - Reg. units and G.Q. units coded 92-N or 93-N in 7c - Ask item 10b - GQ units not coded 92-N or 93-N in 7c - Mark "No" in item 10b without asking b. During the past 12 months, did sales of crops, livestock, and other farm products from this place amount to \$1,000 or more? 1 Yes 2 No (11) 34

17. Record of calls 59-69 Month Date Beginning time Ending time Completed Mark (X) 1 2 3 4 5 6

11. CLASSIFICATION OF LIVING QUARTERS - Mark by observation a. LOCATION of unit 35 Unit is: 1 In Group Quarters - Refer to GQ Table on pages 4-7 through 4-15 of the 11-8, FR Listing and Coverage Manual; then complete 11c or d 2 NOT in Group Quarters (11b) b. Access 36 1 Direct (11c) 2 Through another unit - Not a separate HU; combine with unit through which access is gained. (Apply merged unit procedures if additional living quarters space was listed separately.) c. HOUSING unit (Mark one) 01 House, apartment, flat 02 HU in nontransient hotel, motel, etc. 03 HU-permanent in transient hotel, motel, etc. 04 HU in rooming house 05 Mobile home or trailer with no permanent room added 06 Mobile home or trailer with one or more permanent rooms added 07 HU not specified above - Describe d. GROUP QUARTERS (GQ) unit (Mark one) 37-38 08 Quarters not HU in rooming or boarding house 09 Unit not permanent in transient hotel, motel, etc. 10 Unoccupied site for mobile home, trailer, or tent 11 Student quarters in college dormitory 12 GQ unit not specified above - Describe

18. List column numbers of persons requiring callbacks, and indicate reason(s). None Person No. S.S No. Other Person No. S.S No. Other

12a. What is the telephone number here? 39 Area code/number 40-49 0 None b. Is there any working telephone located INSIDE your home? 1 Yes 2 No 50 13. Interview observed? 1 Yes 2 No 51

19. Record of additional contacts 78-81 Month Date Beginning time Ending time Completed Person No. 1 2 3 4

14a. Field representative's name Code 52-53 b. Language of interview 54 1 English 2 Spanish 3 Both English and Spanish 4 Other

A. HOUSEHOLD COMPOSITION PAGE

1

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

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

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

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

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

d. Do all of the persons you have named usually live here?

- Yes (2)
 No (APPLY HOUSEHOLD MEMBERSHIP RULES. Delete nonhousehold members by an "X" from 1-C2 and enter reason.)

Probe if necessary:

Does -- usually live somewhere else?

Ask for all persons beginning with column 2:

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

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

REFERENCE PERIODS

A1

2-WEEK PERIOD

12-MONTH DATE

13-MONTH HOSPITAL DATE

A2

ASK CONDITION LIST _____

A3

Refer to ages of all HH members.

4a. Are any of the persons in this household now on full-time active duty with the armed forces?

- Yes (4b) No (5)

b. Who is this?

Mark "AF member" box in person's column

c. Anyone else?

- Yes (Reask 4b and c) No (4d)

Ask for each person with "AF member" box marked in 4b.

d. Where does -- usually live and sleep, here or somewhere else?

Mark box in person's column.

HAND CARD O.

5a. Are any of those groups -- National origin or ancestry? (Where did -- ancestors come from?)

b. Please give me the number of the group. Circle all that apply.

- | | | | |
|------------------|----------------------|--------------------------|-------------------|
| 1 - Puerto Rican | 3 - Mexican/Mexicano | 5 - Chicano | 7 - Other Spanish |
| 2 - Cuban | 4 - Mexican American | 6 - Other Latin American | |

HAND CARD R. Ask first alternative for first person; ask second alternative for other persons.

6a. What is the number of the group or groups which represents -- race?
What is -- race?

Circle all that apply.

- | | | | | |
|----------------------------|------------|--------------|-------------------|---------------------------|
| 1 - White | 4 - Eskimo | 6 - Chinese | 10 - Vietnamese | 14 - Guamanian |
| 2 - Black/African American | 5 - Aleut | 7 - Filipino | 11 - Japanese | 15 - Other API - Specify |
| 3 - Indian (American) | | 8 - Hawaiian | 12 - Asian Indian | 16 - Other race - Specify |
| | | 9 - Korean | 13 - Samoan | |

Ask if multiple entries in 6a:

b. Which of those groups, that is, (entries in 6a) would you say BEST represents -- race?

c. Mark observed race of respondent(s) only.

A4

Refer to item 6 "Status" on the Household Page.

A5

Refer to 5a and 6a above for all household members. Mark (X) first appropriate box.

7. Enter person number of the respondent and then read:

Not every household in our survey is asked all questions. I have all the information about your household that I need at this time.

END INTERVIEW

1.	First name	Mid. init.	Age
	Last name		Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F
2.	Relationship REFERENCE PERSON		
3.	Date of birth	Date	Year
	Month		
C1	HOSP.	WORK	RD
	00 <input type="checkbox"/> None	1 <input type="checkbox"/> Wa 2 <input type="checkbox"/> Wb	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	Number		2-WK. DV 00 <input type="checkbox"/> None
			Number

C2	LA	RA	DV	INJ.	CL	LTR	HS	COND.
	LA	RA	DV	INJ.	CL	LTR	HS	COND.
	LA	RA	DV	INJ.	CL	LTR	HS	COND.

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

4b. AF member

4d. Living at home (Exclude from health questions)
 Not living at home (Delete from household by an "X" from 1-C2)

5a. 1 Yes (5b)
 2 No (NP)

b. 1 2 3 4 5 6 7

6a. 1 2 3 4 5 6 7 8 9
 10 11 12 13 14 15 16

(Specify)

b. 1 2 3 4 5 6 7 8 9
 10 11 12 13 14 15 16

(Specify)

c. 1 W 2 B 3 O

A4 S (Item A5)
 I (Next page)

A5 Any "Yes" in 5a (Next page)
 Any "2" in 6a (Next page)
 All others (7)

Person number _____ Respondent

4b. AF member

AF member

4b. AF member

AF member

4d. Living at home (Exclude from health questions)
 Not living at home (Delete from household by an "X" from 1-C2)

Living at home (Exclude from health questions)
 Not living at home (Delete from household by an "X" from 1-C2)

4d. Living at home (Exclude from health questions)
 Not living at home (Delete from household by an "X" from 1-C2)

Living at home (Exclude from health questions)
 Not living at home (Delete from household by an "X" from 1-C2)

5a. 1 Yes (5b)
2 No (NP)

1 Yes (5b)
2 No (NP)

5a. 1 Yes (5b)
2 No (NP)

1 Yes (5b)
2 No (NP)

b.
1 2 3 4 5 6 7

1 2 3 4 5 6 7

b.
1 2 3 4 5 6 7

1 2 3 4 5 6 7

6a. 1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

6a. 1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

b.
1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

b.
1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

1 2 3 4 5 6 7 8 9
10 11 12 13 14 15 16

(Specify)

c. 1 W 2 B 3 O

1 W 2 B 3 O

c. 1 W 2 B 3 O

1 W 2 B 3 O

FOOTNOTES

INTRODUCTION AND HOSPITAL PROBE

If related persons 17 and over are listed in addition to the respondent and are not present, say:
We would like to have all adult family members who are at home take part in the interview. Are (names of persons 17 and over) at home now? If "Yes," ask: Could they join us? (Allow time)

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

HOSPITAL PROBE

1a. Since (13-month hospital date) a year ago, was -- a patient in a hospital OVERNIGHT?

1a.

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

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

b.

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

Ask for each child under one:

2a. Was -- born in a hospital?

2a.

- 1 Yes (2b)
2 No (NP)

Ask for mother and child:

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

b.

- 1 Yes (NP)
2 No (Correct 1 and "HOSP." box)

FOOTNOTES

1a.	1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (Mark "HOSP." box, THEN NP)	1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (Mark "HOSP." box, THEN NP)	1a.
b.	_____ } (Make entry in "HOSP." box THEN NP) Number of times	_____ } (Make entry in "HOSP." box THEN NP) Number of times	b.
2a.	1 <input type="checkbox"/> Yes (2b) 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes (2b) 2 <input type="checkbox"/> No (NP)	2a.
b.	1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No (Correct 1 and "HOSP." box)	1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No (Correct 1 and "HOSP." box)	b.

FOOTNOTES

B. LIMITATION OF ACTIVITIES PAGE

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

B1	1 <input type="checkbox"/> 18-69 (1) 2 <input type="checkbox"/> Other (NP)	1 <input type="checkbox"/> 18-69 (1) 2 <input type="checkbox"/> Other (NP)	B1	1 <input type="checkbox"/> 18-69 (1) 2 <input type="checkbox"/> Other (NP)	1 <input type="checkbox"/> 18-69 (1) 2 <input type="checkbox"/> Other (NP)
1.	1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5)	1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5)	1.	1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5)	1 <input type="checkbox"/> Working (2) 2 <input type="checkbox"/> Keeping house (3) 3 <input type="checkbox"/> Going to school (5) 4 <input type="checkbox"/> Something else (5)
2a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No	2a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No
b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (6)	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (6)	b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (6)	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No (6)
3a.	4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No	4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No	3a.	4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No	4 <input type="checkbox"/> Yes (4) <input type="checkbox"/> No
b.	5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)	5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)	b.	5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)	5 <input type="checkbox"/> Yes (4) 6 <input type="checkbox"/> No (5)
4a.	(Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)	(Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)	4a.	(Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)	(Enter condition in C2, THEN 4b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 4c)
b.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d)	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d)	b.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d)	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No (4d)
c.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 4a and b) <input type="checkbox"/> No
d.	<input type="checkbox"/> Only 1 condition _____ Main cause	<input type="checkbox"/> Only 1 condition _____ Main cause	d.	<input type="checkbox"/> Only 1 condition _____ Main cause	<input type="checkbox"/> Only 1 condition _____ Main cause
5a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No	5a.	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (7) <input type="checkbox"/> No
b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No	b.	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes (7) 3 <input type="checkbox"/> No
B2	1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6)	1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6)	B2	1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6)	1 <input type="checkbox"/> "Yes" in 3a or 3b (NP) 2 <input type="checkbox"/> Other (6)
6a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	6a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
b.	_____ Limitation	_____ Limitation	b.	_____ Limitation	_____ Limitation
7a.	(Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)	(Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)	7a.	(Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)	(Enter condition in C2, THEN 7b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 7c)
b.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)	b.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No (7d)
c.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 7a and b) <input type="checkbox"/> No
d.	<input type="checkbox"/> Only 1 condition _____ Main cause	<input type="checkbox"/> Only 1 condition _____ Main cause	d.	<input type="checkbox"/> Only 1 condition _____ Main cause	<input type="checkbox"/> Only 1 condition _____ Main cause

B3	0 <input type="checkbox"/> Under 5 (10) 2 <input type="checkbox"/> 18-69 (NP) 1 <input type="checkbox"/> 5-17 (11) 3 <input type="checkbox"/> 70 and over (8)	0 <input type="checkbox"/> Under 5 (10) 2 <input type="checkbox"/> 18-69 (NP) 1 <input type="checkbox"/> 5-17 (11) 3 <input type="checkbox"/> 70 and over (8)	B3	0 <input type="checkbox"/> Under 5 (10) 2 <input type="checkbox"/> 18-69 (NP) 1 <input type="checkbox"/> 5-17 (11) 3 <input type="checkbox"/> 70 and over (8)	0 <input type="checkbox"/> Under 5 (10) 2 <input type="checkbox"/> 18-69 (NP) 1 <input type="checkbox"/> 5-17 (11) 3 <input type="checkbox"/> 70 and over (8)
8.	1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house 3 <input type="checkbox"/> Going to school 4 <input type="checkbox"/> Something else	1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house 3 <input type="checkbox"/> Going to school 4 <input type="checkbox"/> Something else	8.	1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house 3 <input type="checkbox"/> Going to school 4 <input type="checkbox"/> Something else	1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house 3 <input type="checkbox"/> Going to school 4 <input type="checkbox"/> Something else
9a.	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	9a.	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
b.	2 <input type="checkbox"/> Yes (13) 3 <input type="checkbox"/> No (12)	2 <input type="checkbox"/> Yes (13) 3 <input type="checkbox"/> No (12)	b.	2 <input type="checkbox"/> Yes (13) 3 <input type="checkbox"/> No (12)	2 <input type="checkbox"/> Yes (13) 3 <input type="checkbox"/> No (12)
10a.	<input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13)	<input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13)	10a.	<input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13)	<input type="checkbox"/> Yes 0 <input type="checkbox"/> No (13)
b.	1 <input type="checkbox"/> Yes (13) 2 <input type="checkbox"/> No (12)	1 <input type="checkbox"/> Yes (13) 2 <input type="checkbox"/> No (12)	b.	1 <input type="checkbox"/> Yes (13) 2 <input type="checkbox"/> No (12)	1 <input type="checkbox"/> Yes (13) 2 <input type="checkbox"/> No (12)
11a.	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	11a.	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
b.	2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	b.	2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	2 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
c.	3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	c.	3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No	3 <input type="checkbox"/> Yes (13) <input type="checkbox"/> No
d.	4 <input type="checkbox"/> Yes (13) 5 <input type="checkbox"/> No	4 <input type="checkbox"/> Yes (13) 5 <input type="checkbox"/> No	d.	4 <input type="checkbox"/> Yes (13) 5 <input type="checkbox"/> No	4 <input type="checkbox"/> Yes (13) 5 <input type="checkbox"/> No
12a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	12a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
b.	_____ Limitation	_____ Limitation	b.	_____ Limitation	_____ Limitation
13a.	(Enter condition in C2, THEN 13b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c)	(Enter condition in C2, THEN 13b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c)	13a.	(Enter condition in C2, THEN 13b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c)	(Enter condition in C2, THEN 13b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 13c)
b.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d)	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d)	b.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d)	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No (13d)
c.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 13a and b) <input type="checkbox"/> No
d.	<input type="checkbox"/> Only 1 condition _____ Main cause	<input type="checkbox"/> Only 1 condition _____ Main cause	d.	<input type="checkbox"/> Only 1 condition _____ Main cause	<input type="checkbox"/> Only 1 condition _____ Main cause

FOOTNOTES

B. LIMITATION OF ACTIVITIES PAGE, Continued

B4	Refer to age.	B4	0 <input type="checkbox"/> Under 5 (NP) 2 <input type="checkbox"/> 60-69 (14) 1 <input type="checkbox"/> 5-59 (B5) 3 <input type="checkbox"/> 70 and over (NP)
B5	Refer to "Old age" and "LA" boxes. Mark first appropriate box.	B5	<input type="checkbox"/> "Old age" box marked (14) <input type="checkbox"/> Entry in "LA" box (14) <input type="checkbox"/> Other (NP)
14a. Because of any impairment or health problem, does -- need the help of other persons with -- personal care needs, such as eating, bathing, dressing, or getting around this home? ----- If under 18, skip to next person; otherwise ask: b. Because of any impairment or health problem, does -- need the help of other persons in handling -- routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?		14a.	1 <input type="checkbox"/> Yes (15) <input type="checkbox"/> No b. 2 <input type="checkbox"/> Yes (15) 3 <input type="checkbox"/> No (NP)
15a. What (other) condition causes this? Ask if injury or operation: When did [the (injury) occur?/ -- have the operation?] Ask if operation over 3 months ago: For what condition did -- have the operation? If pregnancy/delivery or 0-3 months injury or operation -- Reask question 14 where limitation reported, saying: Except for -- (condition), ...? OR reask 15b/c. ----- b. Besides (condition) is there any other condition that causes this limitation? ----- c. Is this limitation caused by any (other) specific condition? ----- Mark box if only one condition. d. Which of these conditions would you say is the MAIN cause of this limitation?		15a.	(Enter condition in C2, THEN 15b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 15c) b. <input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No (15d) c. <input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No d. <input type="checkbox"/> Only 1 condition _____ Main cause

FOOTNOTES

B4	0 <input type="checkbox"/> Under 5 (NP) 2 <input type="checkbox"/> 60-69 (14) 1 <input type="checkbox"/> 5-59 (B5) 3 <input type="checkbox"/> 70 and over (NP)	0 <input type="checkbox"/> Under 5 (NP) 2 <input type="checkbox"/> 60-69 (14) 1 <input type="checkbox"/> 5-59 (B5) 3 <input type="checkbox"/> 70 and over (NP)	B4	0 <input type="checkbox"/> Under 5 (NP) 2 <input type="checkbox"/> 60-69 (14) 1 <input type="checkbox"/> 5-59 (B5) 3 <input type="checkbox"/> 70 and over (NP)
B5	<input type="checkbox"/> "Old age" box marked (14) <input type="checkbox"/> Entry in "LA" box (14): <input type="checkbox"/> Other (NP)	<input type="checkbox"/> "Old age" box marked (14) <input type="checkbox"/> Entry in "LA" box (14) <input type="checkbox"/> Other (NP)	B5	<input type="checkbox"/> "Old age" box marked (14) <input type="checkbox"/> Entry in "LA" box (14) <input type="checkbox"/> Other (NP)
14a.	1 <input type="checkbox"/> Yes (15) <input type="checkbox"/> No	1 <input type="checkbox"/> Yes (15) <input type="checkbox"/> No	14a.	1 <input type="checkbox"/> Yes (15) <input type="checkbox"/> No
b.	2 <input type="checkbox"/> Yes (15) 3 <input type="checkbox"/> No (NP)	2 <input type="checkbox"/> Yes (15) 3 <input type="checkbox"/> No (NP)	b.	2 <input type="checkbox"/> Yes (15) 3 <input type="checkbox"/> No (NP)
15a.	(Enter condition in C2, THEN 15b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 15c)	(Enter condition in C2, THEN 15b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 15c)	15a.	(Enter condition in C2, THEN 15b) 1 <input type="checkbox"/> Old age (Mark "Old age" box, THEN 15c)
b.	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No (15d)	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No (15d)	b.	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No (15d)
c.	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (Reask 15a and b) <input type="checkbox"/> No
d.	<input type="checkbox"/> Only 1 condition Main cause _____	<input type="checkbox"/> Only 1 condition Main cause _____	d.	<input type="checkbox"/> Only 1 condition Main cause _____

FOOTNOTES

D. RESTRICTED ACTIVITY PAGE PERSON 1*Hand calendar.***{The next questions refer to the 2 weeks outlined in red on that calendar, beginning Monday, (date) and ending this past Sunday (date).}****D1***Refer to age.* Under 5 (4) 5-17 (3) 18 and over (1)**1a. DURING THOSE 2 WEEKS, did -- work at any time at a job or business not counting work around the house? (Include unpaid work in the family [farm/business].)**1 Yes (*Mark "Wa" box, THEN 2*) 2 No**b. Even though -- did not work during those 2 weeks, did -- have a job or business?**1 Yes (*Mark "Wb" box, THEN 2*) 2 No (4)**2a. During those 2 weeks, did -- miss any time from a job or business because of illness or injury?** Yes 00 No (4)**b. During that 2-week period, how many days did -- miss more than half of the day from -- job or business because of illness or injury?**00 None (4)

No. of work-loss days

(4)

3a. During those 2 weeks, did -- miss any time from school because of illness or injury? Yes 00 No (4)**b. During that 2-week period, how many days did -- miss more than half of the day from school because of illness or injury?**00 None

No. of school-loss days

4a. During those 2 weeks, did -- stay in bed because of illness or injury? Yes 00 No (6)**b. During that 2-week period, how many days did -- stay in bed more than half of the day because of illness or injury?**00 None (6)

No. of bed days

(D2)

*Refer to 2b and 3b.***D2** No days in 2b or 3b (6)
 1 or more days in 2b or 3b (5)**5. On how many of the (number in 2b or 3b) days missed from [work/school] did -- stay in bed more than half of the day because of illness or injury?**00 None

No. of days

*Refer to 2b, 3b, and 4b.***6a. (Not counting the day(s) [missed from work missed from school (and) in bed],****Was there any (OTHER) time during those 2 weeks that -- cut down on the things -- usually does because of illness or injury?** Yes00 No (D3)**b. (Again, not counting the day(s) [missed from work missed from school (and) in bed],****During that period, how many (OTHER) days did -- cut down for more than half of the days because of illness or injury?**00 None

No. of cut-down days

*Refer to 2-6.***D3** No days in 2-6 (*Mark "No" in RD, THEN NP*)
 1 or more days in 2-6 (*Mark "Yes" in RD, THEN 7*)*Refer to 2b, 3b, 4b, and 6b.***7a. What (other) condition caused -- to [miss work miss school (or) stay in bed (or) cut down] during those 2 weeks?***(Enter condition in C2, THEN 7b)***b. Did any other condition cause -- to [miss work miss school (or) stay in bed (or) cut down] during that period?**1 Yes (*Reask 7a and b*)2 No

FOOTNOTES

D. RESTRICTED ACTIVITY PAGE PERSON 2

Hand calendar.

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

D1

Refer to age.

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

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

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

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

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

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

Yes 00 No (4)

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

00 None (4)

No. of work-loss days

(4)

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

Yes 00 No (4)

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

00 None

No. of school-loss days

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

Yes 00 No (6)

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

00 None (6)

No. of bed days

(D2)

Refer to 2b and 3b.

D2

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

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

00 None

No. of days

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

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

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

Yes

00 No (D3)

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

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

00 None

No. of cut-down days

D3

Refer to 2-6.

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

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

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

(Enter condition in C2, THEN 7b)

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

1 Yes (Reask 7a and b)

2 No

FOOTNOTES

D. RESTRICTED ACTIVITY PAGE PERSON 3

Hand calendar.

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

D1

Refer to age.

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

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

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

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

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

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

Yes 00 No (4)

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

00 None (4)

No. of work-loss days

(4)

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

Yes 00 No (4)

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

00 None

No. of school-loss days

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

Yes 00 No (6)

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

00 None (6)

No. of bed days

(D2)

D2

Refer to 2b and 3b.

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

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

00 None _____ No. of days

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

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

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

Yes 00 No (D3)

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

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

00 None

No. of cut-down days

D3

Refer to 2-6.

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

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

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

(Enter condition in C2, THEN 7b)

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

1 Yes (Reask 7a and b) 2 No

FOOTNOTES

D. RESTRICTED ACTIVITY PAGE PERSON 4

Hand calendar.

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

D1

Refer to age.

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

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

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

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

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

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

 Yes No (4)

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

 None (4)

No. of work-loss days

(4)

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

 Yes No (4)

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

 None

No. of school-loss days

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

 Yes No (6)

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

 None (6)

No. of bed days

(D2)

Refer to 2b and 3b.

D2
 No days in 2b or 3b (6)
 1 or more days in 2b or 3b (5)

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

 None

No. of days

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

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

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

 Yes

 No (D3)

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

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

 None

No. of cut-down days

Refer to 2-6.

D3
 No days in 2-6 (Mark "No" in RD, THEN NP)
 1 or more days in 2-6 (Mark "Yes" in RD, THEN 7)

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

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

(Enter condition in C2, THEN 7b)

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

 Yes (Reask 7a and b)

 No

FOOTNOTES

D. RESTRICTED ACTIVITY PAGE PERSON 5

Hand calendar.

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

D1

Refer to age.

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

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

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

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

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

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

Yes 00 No (4)

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

00 None (4)

No. of work-loss days

(4)

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

Yes 00 No (4)

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

00 None

No. of school-loss days

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

Yes 00 No (6)

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

00 None (6)

No. of bed days

(D2)

Refer to 2b and 3b.

D2

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

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

00 None

No. of days

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

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

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

Yes

00 No (D3)

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

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

00 None

No. of cut-down days

Refer to 2-6.

D3

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

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

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

(Enter condition in C2, THEN 7b)

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

1 Yes (Reask 7a and b)

2 No

FOOTNOTES

FOOTNOTES

E. 2-WEEK DOCTOR VISITS PROBE PAGE

Read to respondent: **These next questions are about health care received during the 2 weeks outlined in red on that calendar.**

E1

Refer to age.

E1

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

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

1a. and b.

00 None

Number of times

} (NP)

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

2a. (Besides the time(s) you just told me about) During those 2 weeks, did anyone in the family receive health care at home or go to a doctor's office, clinic, hospital or some other place? Include care from a nurse or anyone working with or for a medical doctor. Do not count times while an overnight patient in a hospital.

Yes

No (3a)

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

2b.

DR Visit

c. Anyone else?

Yes (Reask 2b and c)

No

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

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

d.

Number of times

3a. (Besides the time(s) you already told me about) During those 2 weeks, did anyone in the family get any medical advice, prescriptions or test results over the PHONE from a doctor, nurse, or anyone working with or for a medical doctor?

Yes

No (E2)

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

3b.

Phone call

c. Were there any calls about anyone else?

Yes (Reask 3b and c)

No

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

d. How many telephone calls were made about --?

d.

Number of calls

E2

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

FOOTNOTES

E1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)	E1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)
1a. and b.	00 <input type="checkbox"/> None <input type="text"/> Number of times } (NP)	00 <input type="checkbox"/> None <input type="text"/> Number of times } (NP)	1a. and b.	00 <input type="checkbox"/> None <input type="text"/> Number of times } (NP)	00 <input type="checkbox"/> None <input type="text"/> Number of times } (NP)
2b.	<input type="checkbox"/> DR Visit	<input type="checkbox"/> DR Visit	2b.	<input type="checkbox"/> DR Visit	<input type="checkbox"/> DR Visit
d.	<input type="text"/> Number of times	<input type="text"/> Number of times	d.	<input type="text"/> Number of times	<input type="text"/> Number of times
3b.	<input type="checkbox"/> Phone call	<input type="checkbox"/> Phone call	3b.	<input type="checkbox"/> Phone call	<input type="checkbox"/> Phone call
d.	<input type="text"/> Number of calls	<input type="text"/> Number of calls	d.	<input type="text"/> Number of calls	<input type="text"/> Number of calls

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

FOOTNOTES

F. 2-WEEK DOCTOR VISITS PAGE

DR VISIT 1

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

PERSON NUMBER _____

F1 Refer to age.

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

1a. On what (other) date(s) during those 2 weeks did -- see or talk to a medical doctor, nurse, or doctor's assistant?

1a. and b.

Month _____ Date _____ OR { 7777 Last week
8888 Week before

b. On what (other) date(s) during those 2 weeks did anyone see or talk to a medical doctor, nurse, or doctor's assistant about --?

c. 1 Yes (Reask 1a or b and c)
2 No (Ask 2-6 for each visit)

Ask after last DR visit column for this person:

c. Were there any other visits or calls for -- during that period?
Make necessary correction to 2-Wk. DV box in C1.

2. Where did -- receive health care on (date in 1), at a doctor's office, clinic, hospital, some other place, or was this a telephone call?

2.

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

If doctor's office: Was this office in a hospital?

If hospital: Was it the outpatient clinic or the emergency room?

If clinic: Was it a hospital outpatient clinic, a company clinic, a public health clinic, or some other kind of clinic?

If lab: Was this lab in a hospital?

What was done during this visit? (Footnote)

Ask 3b if under 14.

3a. Did -- actually talk to a medical doctor?

3a. and b.

1 Yes (3f) 8 DK if M.D. (3c)
2 No (3c) 9 DK who was seen (3f)

b. Did anyone actually talk to a medical doctor about --?

c.

_____ 99 DK
Type

c. What type of medical person or assistant was talked to?

d.

1 One (3f) 2 More 3 None (4) 9 DK

d. Does the (entry in 3c) work with or for ONE doctor or MORE than one doctor?

e. and f.

1 GP (4) 2 Specialist (3g) 9 DK (4)

e. For this [visit/call] what kind of doctor was the (entry in 3c) working with or for -- a general practitioner or specialist?

f. Is that doctor a general practitioner or a specialist?

g.

_____ Kind of specialist

g. What kind of specialist?

Ask 4b if under 14.

4a. For what condition did -- see or talk to the [doctor/(entry in 3c)] on (date in 1)?
Mark first appropriate box.

4a. and b.

1 Condition (Item C2, THEN 4g)
2 Pregnancy (4e)
3 Test(s) or examination (4c)
8 Other (Specify) _____ (4g)

b. For what condition did anyone see or talk to the [doctor/(entry in 3c)] about -- on (date in 1)? Mark first appropriate box.

c.

Yes (4h) No

c. Was a condition found as a result of the [test(s)/examination]?

d.

Yes (4h) No (4g)

d. Was this [test/examination] because of a specific condition -- had?

e.

Yes No (4g)

e. During the past 2 weeks was -- sick because of her pregnancy?

f.

_____ (Item C2, THEN 4g)
Condition

f. What was the matter?

g.

Yes No (5)

g. During this [visit/call] was the [doctor/(entry in 3c)] talked to about any (other) condition?

h.

Pregnancy (4e) _____ (Item C2, THEN 4g)
Condition

h. What was the condition?

Mark box if "Telephone" in 2.

5a. Did -- have any kind of surgery or operation during this visit, including bone settings and stitches?

5a.

0 Telephone in 2 (Next Dr. visit) 1 Yes 2 No (6)

b. What was the name of the surgery or operation?
If name of operation not known, describe what was done.

b.

(1) _____
(2) _____

c. Was there any other surgery or operation during this visit?

c.

Yes (Reask 5b and c) No

Go to next DV if "Home" in 2.

6. In what city (town), county, and State is the (place in 2) located?

6.

City/County _____ / _____
State/ZIP Code _____ / _____

DR VISIT 2		DR VISIT 3		DR VISIT 4	
PERSON NUMBER _____		PERSON NUMBER _____		PERSON NUMBER _____	
F1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)	F1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)	F1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)
1a. and b.	Month _____ Date _____ OR { 7777 <input type="checkbox"/> Last week 8888 <input type="checkbox"/> Week before	1a. and b.	Month _____ Date _____ OR { 7777 <input type="checkbox"/> Last week 8888 <input type="checkbox"/> Week before	1a. and b.	Month _____ Date _____ OR { 7777 <input type="checkbox"/> Last week 8888 <input type="checkbox"/> Week before
c.	1 <input type="checkbox"/> Yes (Reask 1a or b and c) 2 <input type="checkbox"/> No (Ask 2-6 for each visit)	c.	1 <input type="checkbox"/> Yes (Reask 1a or b and c) 2 <input type="checkbox"/> No (Ask 2-6 for each visit)	c.	1 <input type="checkbox"/> Yes (Reask 1a or b and c) 2 <input type="checkbox"/> No (Ask 2-6 for each visit)
2.	01 <input type="checkbox"/> Telephone Not in hospital: 02 <input type="checkbox"/> Home 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Co. or Ind. clinic 05 <input type="checkbox"/> Other clinic 06 <input type="checkbox"/> Lab 07 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Hospital: 08 <input type="checkbox"/> O. P. clinic 09 <input type="checkbox"/> Emergency room 10 <input type="checkbox"/> Doctor's office 11 <input type="checkbox"/> Lab 12 <input type="checkbox"/> Overnight patient (6) 88 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/>	2.	01 <input type="checkbox"/> Telephone Not in hospital: 02 <input type="checkbox"/> Home 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Co. or Ind. clinic 05 <input type="checkbox"/> Other clinic 06 <input type="checkbox"/> Lab 07 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Hospital: 08 <input type="checkbox"/> O. P. clinic 09 <input type="checkbox"/> Emergency room 10 <input type="checkbox"/> Doctor's office 11 <input type="checkbox"/> Lab 12 <input type="checkbox"/> Overnight patient (6) 88 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/>	2.	01 <input type="checkbox"/> Telephone Not in hospital: 02 <input type="checkbox"/> Home 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Co. or Ind. clinic 05 <input type="checkbox"/> Other clinic 06 <input type="checkbox"/> Lab 07 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Hospital: 08 <input type="checkbox"/> O. P. clinic 09 <input type="checkbox"/> Emergency room 10 <input type="checkbox"/> Doctor's office 11 <input type="checkbox"/> Lab 12 <input type="checkbox"/> Overnight patient (6) 88 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/>
3a. and b.	1 <input type="checkbox"/> Yes (3f) 8 <input type="checkbox"/> DK if M.D. (3c) 2 <input type="checkbox"/> No (3c) 9 <input type="checkbox"/> DK who was seen (3f)	3a. and b.	1 <input type="checkbox"/> Yes (3f) 8 <input type="checkbox"/> DK if M.D. (3c) 2 <input type="checkbox"/> No (3c) 9 <input type="checkbox"/> DK who was seen (3f)	3a. and b.	1 <input type="checkbox"/> Yes (3f) 8 <input type="checkbox"/> DK if M.D. (3c) 2 <input type="checkbox"/> No (3c) 9 <input type="checkbox"/> DK who was seen (3f)
c.	_____ 99 <input type="checkbox"/> DK Type _____	c.	_____ 99 <input type="checkbox"/> DK Type _____	c.	_____ 99 <input type="checkbox"/> DK Type _____
d.	1 <input type="checkbox"/> One (3f) 2 <input type="checkbox"/> More 3 <input type="checkbox"/> None (4) 9 <input type="checkbox"/> DK	d.	1 <input type="checkbox"/> One (3f) 2 <input type="checkbox"/> More 3 <input type="checkbox"/> None (4) 9 <input type="checkbox"/> DK	d.	1 <input type="checkbox"/> One (3f) 2 <input type="checkbox"/> More 3 <input type="checkbox"/> None (4) 9 <input type="checkbox"/> DK
e. and f.	1 <input type="checkbox"/> GP(4) 2 <input type="checkbox"/> Specialist (3g) 9 <input type="checkbox"/> DK (4)	e. and f.	1 <input type="checkbox"/> GP(4) 2 <input type="checkbox"/> Specialist (3g) 9 <input type="checkbox"/> DK (4)	e. and f.	1 <input type="checkbox"/> GP(4) 2 <input type="checkbox"/> Specialist (3g) 9 <input type="checkbox"/> DK (4)
g.	_____ Kind of specialist	g.	_____ Kind of specialist	g.	_____ Kind of specialist
4a. and b.	1 <input type="checkbox"/> Condition (Item C2, THEN 4g) 2 <input type="checkbox"/> Pregnancy (4e) 3 <input type="checkbox"/> Test(s) or examination (4c) 8 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> _____ (4g)	4a. and b.	1 <input type="checkbox"/> Condition (Item C2, THEN 4g) 2 <input type="checkbox"/> Pregnancy (4e) 3 <input type="checkbox"/> Test(s) or examination (4c) 8 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> _____ (4g)	4a. and b.	1 <input type="checkbox"/> Condition (Item C2, THEN 4g) 2 <input type="checkbox"/> Pregnancy (4e) 3 <input type="checkbox"/> Test(s) or examination (4c) 8 <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> _____ (4g)
c.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No
d.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No (4g)	d.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No (4g)	d.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No (4g)
e.	<input type="checkbox"/> Yes <input type="checkbox"/> No (4g)	e.	<input type="checkbox"/> Yes <input type="checkbox"/> No (4g)	e.	<input type="checkbox"/> Yes <input type="checkbox"/> No (4g)
f.	_____ (Item C2, THEN 4g) Condition _____	f.	_____ (Item C2, THEN 4g) Condition _____	f.	_____ (Item C2, THEN 4g) Condition _____
g.	<input type="checkbox"/> Yes <input type="checkbox"/> No (5)	g.	<input type="checkbox"/> Yes <input type="checkbox"/> No (5)	g.	<input type="checkbox"/> Yes <input type="checkbox"/> No (5)
h.	<input type="checkbox"/> Pregnancy (4e) _____ (Item C2, THEN 4g) Condition _____	h.	<input type="checkbox"/> Pregnancy (4e) _____ (Item C2, THEN 4g) Condition _____	h.	<input type="checkbox"/> Pregnancy (4e) _____ (Item C2, THEN 4g) Condition _____
5a.	0 <input type="checkbox"/> Telephone in 2 (Next Dr. visit) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	5a.	0 <input type="checkbox"/> Telephone in 2 (Next Dr. visit) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	5a.	0 <input type="checkbox"/> Telephone in 2 (Next Dr. visit) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)
b.	(1) _____ (2) _____	b.	(1) _____ (2) _____	b.	(1) _____ (2) _____
c.	<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No	c.	<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No
6.	City/County _____ / _____ State/ZIP Code _____ / _____	6.	City/County _____ / _____ State/ZIP Code _____ / _____	6.	City/County _____ / _____ State/ZIP Code _____ / _____

G. HEALTH INDICATOR PAGE

1a. During the 2-week period outlined in red on that calendar, has anyone in the family had an injury from an accident or other cause that you have not yet told me about?

Yes No (2)

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

1b.

Injury

c. What was -- injury?

Enter injury(ies) in person's column.

c.

Injury

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

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

Ask for each injury in 1c:

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

e.

Yes (Enter injury in C2, THEN 1e for next injury)

No (1e for next injury)

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

2.

000 None

_____ No. of days

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

3a.

000 None (3b)

000 Only when overnight patient in hospital

} (NP)

_____ No. of visits

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

b.

1 Interview week (Reask 3b)

2 Less than 1 yr. (Reask 3a)

3 1 yr., less than 2 yrs.

4 2 yrs., less than 5 yrs.

5 5 yrs. or more

0 Never

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

4.

1 Excellent

4 Fair

2 Very good

5 Poor

3 Good

Mark box if under 18.

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

5a.

Under 18 (NP)

_____ Feet _____ Inches

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

b.

_____ Pounds

FOOTNOTES

1b.	<input type="checkbox"/> Injury	<input type="checkbox"/> Injury	1b.	<input type="checkbox"/> Injury	<input type="checkbox"/> Injury
c.	_____ Injury	_____ Injury	c.	_____ Injury	_____ Injury
e.	<input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)	<input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)	e.	<input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)	<input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)

2.	000 <input type="checkbox"/> None _____ No. of days	000 <input type="checkbox"/> None _____ No. of days	2.	000 <input type="checkbox"/> None _____ No. of days	000 <input type="checkbox"/> None _____ No. of days
3a.	000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits	000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits	3a.	000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits	000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits
b.	1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never	1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never	b.	1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never	1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never

4.	1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good	1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good	4.	1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good	1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good
5a.	<input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches	<input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches	5a.	<input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches	<input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches
b.	_____ Pounds	_____ Pounds	b.	_____ Pounds	_____ Pounds

FOOTNOTES

H. CONDITION LISTS 1 AND 2

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

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

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

H. CONDITION LISTS 3 AND 4

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

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

3

- 3a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 3b and c.**
- b. Who was this?**
- c. DURING THE PAST 12 MONTHS, did anyone else have —**
Enter condition and letter in appropriate person's column.
- Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list.*
- Conditions affecting the digestive system.*

A. Gallstones?	<i>Reask 3a.</i>
B. Any other gallbladder trouble?	N. Enteritis?
C. Cirrhosis of the liver?	O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)
D. Fatty liver?	P. Colitis?
E. Hepatitis?	Q. A spastic colon?
F. Yellow jaundice?	R. FREQUENT constipation?
G. Any other liver trouble?	S. Any other bowel trouble?
H. An ulcer?	T. Any other intestinal trouble?
I. A hernia or rupture?	U. Cancer of the stomach, intestines, colon, or rectum?
J. Any disease of the esophagus?	V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system?
K. Gastritis?	<i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i>
L. FREQUENT indigestion?	
M. Any other stomach trouble?	

4

- 4a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 4b and c.**
- b. Who was this?**
- c. DURING THE PAST 12 MONTHS, did anyone else have —**
Enter condition and letter in appropriate person's column.
- A-B are conditions affecting the glandular system.
 C is a blood condition.
 D-I are conditions affecting the nervous system.
 J-Y are conditions affecting the genito-urinary system.*

A. A goiter or other thyroid trouble?	<i>Reask 4a.</i>
B. Diabetes?	N. Any other kidney trouble?
C. Anemia of any kind?	O. Bladder trouble?
D. Epilepsy?	P. Any disease of the genital organs?
E. REPEATED seizures, convulsions, or blackouts?	Q. A missing breast?
F. Multiple sclerosis?	R. Breast cancer?
G. Migraine?	S. * Cancer of the prostate?
H. FREQUENT headaches?	T. * Any other prostate trouble?
I. Neuralgia or neuritis?	U. ** Trouble with menstruation?
J. Nephritis?	V. ** A hysterectomy? If "Yes," ask: For what condition did -- have a hysterectomy?
K. Kidney stones?	W. ** A tumor, cyst, or growth of the uterus or ovaries?
L. REPEATED kidney infections?	X. ** Any other disease of the uterus or ovaries?
M. A missing kidney?	Y. ** Any other female trouble?

**Ask only if males in family.
 **Ask only if females in family.*

H. CONDITION LISTS 5 AND 6

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

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

5

5a. Has anyone in the family {read names} EVER had —

If "Yes," ask 5b and c.

b. Who was this?

c. Has anyone else EVER had —

Enter condition and letter in appropriate person's column.

Conditions affecting the heart and circulatory system.

A. Rheumatic fever?

B. Rheumatic heart disease?

C. Hardening of the arteries or arteriosclerosis?

D. Congenital heart disease?

E. Coronary heart disease?

F. Hypertension, sometimes called high blood pressure?

G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar)

H. A hemorrhage of the brain?

I. Angina pectoris? (pek'to-ris)

J. A myocardial infarction?

K. Any other heart attack?

5d. DURING THE PAST 12 MONTHS, did anyone in the family have —

If "Yes," ask 5e and f.

e. Who was this?

f. DURING THE PAST 12 MONTHS, did anyone else have —

Enter condition and letter in appropriate person's column.

Conditions affecting the heart and circulatory system.

L. Damaged heart valves?

M. Tachycardia or rapid heart?

N. A heart murmur?

O. Any other heart trouble?

P. An aneurysm? (an yoo-rizm)

Q. Any blood clots?

R. Varicose veins?

S. Hemorrhoids or piles?

T. Phlebitis or thrombophlebitis?

U. Any other condition affecting blood circulation?

6

6a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have —

If "Yes," ask 6b and c.

b. Who was this?

c. DURING THE PAST 12 MONTHS, did anyone else have —

Enter condition and letter in appropriate person's column.

Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list.

Conditions affecting the respiratory system.

A. Bronchitis?

B. Asthma?

C. Hay fever?

D. Sinus trouble?

E. A nasal polyp?

F. A deflected or deviated nasal septum?

G. * Tonsilitis or enlargement of the tonsils or adenoids?

H. * Laryngitis?

I. A tumor or growth of the throat, larynx, or trachea?

J. A tumor or growth of the bronchial tube or lung?

Reask 6a.

K. A missing lung?

L. Lung cancer?

M. Emphysema?

N. Pleurisy?

O. Tuberculosis?

P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis?

Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask Q.

** If reported in this list only, ask:*

1. How many times did -- have (condition) in the past 12 months?

If 2 or more times, enter condition in item C2.

If only 1 time, ask:

2. How long did it last? If 1 month or longer, enter in item C2.

If less than 1 month, do not record.

If tonsils or adenoids were removed during past 12 months, enter the condition causing removal in item C2.

FOOTNOTES

J. HOSPITAL PAGE

HOSPITAL STAY 1

1. Refer to C1, "HOSP." box.

1. **PERSON NUMBER** _____

2. You said earlier that -- was a patient in the hospital since (13-month hospital date) a year ago. On what date did -- enter the hospital ([the last time/the time before that])?

2. Month	Date	Year
		19 ____

Record each entry date in a separate Hospital Stay column.

3. How many nights was -- in the hospital?

3. 0000 None (Next HS)
____ Nights

4. For what condition did -- enter the hospital?

- For delivery ask: **Was this a normal delivery?**
If "No," ask: **What was the matter?**
- For newborn ask: **Was the baby normal at birth?**
If "No," ask: **What was the matter?**
- For initial "No condition" ask: **Why did -- enter the hospital?**
- For tests, ask: **What were the results of the tests?**
If no results, ask: **Why were the tests performed?**

4. 1 Normal delivery } (5)
2 Normal at birth }
3 No condition }
 Condition

J1

Refer to questions 2, 3, and 2-week reference period.

J1

- At least one night in 2-week reference period (Enter condition in C2, THEN 5)
- No nights in 2-week reference period (5)

5a. Did -- have any kind of surgery or operation during this stay in the hospital, including bone settings and stitches?

5a. 1 Yes 2 No (6)

b. What was the name of the surgery or operation?
If name of operation not known, describe what was done.

b. (1) _____
(2) _____
(3) _____

c. Was there any other surgery or operation during this stay?

c. Yes (Reask 5b and c) No

6. What is the name and address of this hospital?

6. Name _____
Number and street _____
City or County _____ State _____

FOOTNOTES

HOSPITAL STAY 2				HOSPITAL STAY 3				HOSPITAL STAY 4			
1. PERSON NUMBER _____				1. PERSON NUMBER _____				1. PERSON NUMBER _____			
2. Month		Date		Year		2. Month		Date		Year	
				19 ____						19 ____	
3. 0000 <input type="checkbox"/> None (Next HS) _____ Nights				3. 0000 <input type="checkbox"/> None (Next HS) _____ Nights				3. 0000 <input type="checkbox"/> None (Next HS) _____ Nights			
4. 1 <input type="checkbox"/> Normal delivery } (5) 2 <input type="checkbox"/> Normal at birth } 3 <input type="checkbox"/> No condition } <input type="checkbox"/> Condition <input checked="" type="checkbox"/>				4. 1 <input type="checkbox"/> Normal delivery } (5) 2 <input type="checkbox"/> Normal at birth } 3 <input type="checkbox"/> No condition } <input type="checkbox"/> Condition <input checked="" type="checkbox"/>				4. 1 <input type="checkbox"/> Normal delivery } (5) 2 <input type="checkbox"/> Normal at birth } 3 <input type="checkbox"/> No condition } <input type="checkbox"/> Condition <input checked="" type="checkbox"/>			
J1 <input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2, THEN 5) <input type="checkbox"/> No nights in 2-week reference period (5)				J1 <input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2, THEN 5) <input type="checkbox"/> No nights in 2-week reference period (5)				J1 <input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2, THEN 5) <input type="checkbox"/> No nights in 2-week reference period (5)			
5a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)				5a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)				5a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)			
b. (1) _____ (2) _____ (3) _____				b. (1) _____ (2) _____ (3) _____				b. (1) _____ (2) _____ (3) _____			
c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No				c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No				c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No			
6. Name _____ Number and street _____ City or County _____ State _____				6. Name _____ Number and street _____ City or County _____ State _____				6. Name _____ Number and street _____ City or County _____ State _____			

FOOTNOTES

CONDITION 1

PERSON NO. _____

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when _____ |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

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

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

- Infection Sore Soreness**

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

(Specify) _____

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

- Tumor Cyst Growth**

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

1 "Yes" in "RD" box AND more than 1 condition in C2 (6)8 Other (K2)**6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?** Yes No (K2)**b. During that period, how many days did -- cut down for more than half of the day?**00 None (K2) _____ Days**7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?**00 None _____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?00 None _____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?00 None _____ Days**K2** Condition has "CL LTR" in C2 as source (10) Condition does not have "CL LTR" in C2 as source (K4)**10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)**000 None _____ Days**11. Was -- ever hospitalized for -- (condition in 3b)?**1 Yes 2 No**K3** Missing extremity or organ (K4) Other (12)**12a. Does -- still have this condition?**1 Yes (K4) 2 No**b. Is this condition completely cured or is it under control?**2 Cured 8 Other (Specify) 3 Under control (K4) _____ (K4)**c. About how long did -- have this condition before it was cured?**000 Less than 1 month OR Number { 1 Months
2 Years**d. Was this condition present at any time during the past 12 months?**1 Yes 2 No**K4**0 Not an accident/injury (NC)1 First accident/injury for this person (14)8 Other (13)**13. Is this (condition in 3b) the result of the same accident you already told me about?** Yes (Record condition page number where accident questions first completed.) → _____ (NC)
Page No. No**14. Where did the accident happen?**

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

Mark box if under 18. Under 18 (16)**15a. Was -- under 18 when the accident happened?**1 Yes (16) No**b. Was -- in the Armed Forces when the accident happened?**2 Yes (16) No**c. Was -- at work at -- job or business when the accident happened?**3 Yes 4 No**16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?**1 Yes 2 No (17)**b. Was more than one vehicle involved?**1 Yes 2 No**c. Was [it/either one] moving at the time?**1 Yes 2 No**17a. At the time of the accident what part of the body was hurt?****What kind of injury was it?****Anything else?**

Part(s) of body *	Kind of injury

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

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

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

CONDITION 2

PERSON NO. _____

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when _____ |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

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

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

Infection Sore Soreness

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

(Specify) _____

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

Tumor Cyst Growth

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

1 "Yes" in "RD" box AND more than 1 condition in C2 (6)8 Other (K2)**6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?** Yes No (K2)**b. During that period, how many days did -- cut down for more than half of the day?**00 None (K2)

_____ Days

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

_____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?00 None

_____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?00 None

_____ Days

K2 Condition has "CL LTR" in C2 as source (10) Condition does not have "CL LTR" in C2 as source (K4)**10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)**000 None

_____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?1 Yes2 No**K3** Missing extremity or organ (K4) Other (12)**12a. Does -- still have this condition?**1 Yes (K4)2 No**b. Is this condition completely cured or is it under control?**2 Cured8 Other (Specify) 3 Under control (K4)

_____ (K4)

c. About how long did -- have this condition before it was cured?000 Less than 1 month

OR

Number

1 Months2 Years**d. Was this condition present at any time during the past 12 months?**1 Yes2 No**K4**0 Not an accident/injury (NC)1 First accident/injury for this person (14)8 Other (13)**13. Is this (condition in 3b) the result of the same accident you already told me about?** Yes (Record condition page number where accident questions first completed.) → _____ (NC)
Page No. No**14. Where did the accident happen?**1 At home (inside house)2 At home (adjacent premises)3 Street and highway (includes roadway and public sidewalk)4 Farm5 Industrial place (includes premises) (Specify) _____6 School (includes premises)7 Place of recreation and sports, except at school8 Other (Specify)

Mark box if under 18.

 Under 18 (16)**15a. Was -- under 18 when the accident happened?**1 Yes (16) No**b. Was -- in the Armed Forces when the accident happened?**2 Yes (16) No**c. Was -- at work at -- job or business when the accident happened?**3 Yes4 No**16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?**1 Yes2 No (17)**b. Was more than one vehicle involved?**1 Yes2 No**c. Was [it/either one] moving at the time?**1 Yes2 No**17a. At the time of the accident what part of the body was hurt?**

What kind of injury was it?

Anything else?

Part(s) of body *	Kind of injury

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

b. What part of the body is affected now?

How is -- (part of body) affected?

Is -- affected in any other way?

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

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

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

- Infection Sore Soreness**

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

(Specify) _____

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

- Tumor Cyst Growth**

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

- 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?

- Yes No (K2)

b. During that period, how many days did -- cut down for more than half of the day?

00 None (K2) _____ Days

7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?

00 None _____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?

00 None _____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?

00 None _____ Days

K2

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

10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)

000 None _____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?

- 1 Yes 2 No

K3

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

12a. Does -- still have this condition?

- 1 Yes (K4) 2 No

b. Is this condition completely cured or is it under control?

- 2 Cured 8 Other (Specify)
 3 Under control (K4)

_____ (K4)

c. About how long did -- have this condition before it was cured?

000 Less than 1 month OR _____ Number 1 Months
 2 Years

d. Was this condition present at any time during the past 12 months?

- 1 Yes 2 No

K4

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

13. Is this (condition in 3b) the result of the same accident you already told me about?

- Yes (Record condition page number where accident questions first completed.) → _____ (NC)
 Page No.
 No

14. Where did the accident happen?

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

Mark box if under 18. Under 18 (16)

15a. Was -- under 18 when the accident happened?

- 1 Yes (16) No

b. Was -- in the Armed Forces when the accident happened?

- 2 Yes (16) No

c. Was -- at work at -- job or business when the accident happened?

- 3 Yes 4 No

16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?

- 1 Yes 2 No (17)

b. Was more than one vehicle involved?

- 1 Yes 2 No

c. Was [it/either one] moving at the time?

- 1 Yes 2 No

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

Part(s) of body *	Kind of injury

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

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

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

- 1 Yes (Probe, then 5)
2 No

Ask probes as necessary. Record responses in 3c:

(How did the accident happen?)
(What was -- doing at the time of the injury?)

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

Infection Sore Soreness

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

(Specify) _____

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

Tumor Cyst Growth

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

- 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?

- Yes No (K2)

b. During that period, how many days did -- cut down for more than half of the day?

- 00 None (K2) _____ Days

7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?

- 00 None _____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?

- 00 None _____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?

- 00 None _____ Days

K2

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

10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)

- 000 None _____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?

- 1 Yes 2 No

K3

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

12a. Does -- still have this condition?

- 1 Yes (K4) 2 No

b. Is this condition completely cured or is it under control?

- 2 Cured 8 Other (Specify)
 3 Under control (K4) _____ (K4)

c. About how long did -- have this condition before it was cured?

- 000 Less than 1 month OR _____ Number $\left\{ \begin{array}{l} 1 \text{ Months} \\ 2 \text{ Years} \end{array} \right.$

d. Was this condition present at any time during the past 12 months?

- 1 Yes 2 No

K4

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

13. Is this (condition in 3b) the result of the same accident you already told me about?

- Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No.
 No

14. Where did the accident happen?

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

Mark box if under 18. Under 18 (16)

15a. Was -- under 18 when the accident happened?

- 1 Yes (16) No

b. Was -- in the Armed Forces when the accident happened?

- 2 Yes (16) No

c. Was -- at work at -- job or business when the accident happened?

- 3 Yes 4 No

16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?

- 1 Yes 2 No (17)

b. Was more than one vehicle involved?

- 1 Yes 2 No

c. Was [it/either one] moving at the time?

- 1 Yes 2 No

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

Part(s) of body *	Kind of injury

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

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

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

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

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

- Infection Sore Soreness**

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

(Specify) _____

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

- Tumor Cyst Growth**

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

1 "Yes" in "RD" box AND more than 1 condition in C2 (6)8 Other (K2)**6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?** Yes No (K2)**b. During that period, how many days did -- cut down for more than half of the day?**00 None (K2)

_____ Days

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

_____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?00 None

_____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?00 None

_____ Days

K2 Condition has "CL LTR" in C2 as source (10) Condition does not have "CL LTR" in C2 as source (K4)**10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)**000 None

_____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?1 Yes2 No**K3** Missing extremity or organ (K4) Other (12)**12a. Does -- still have this condition?**1 Yes (K4)2 No**b. Is this condition completely cured or is it under control?**2 Cured8 Other (Specify) 3 Under control (K4)

_____ (K4)

c. About how long did -- have this condition before it was cured?000 Less than 1 month

OR

Number

1 Months2 Years**d. Was this condition present at any time during the past 12 months?**1 Yes2 No**K4**0 Not an accident/injury (NC)1 First accident/injury for this person (14)8 Other (13)**13. Is this (condition in 3b) the result of the same accident you already told me about?** Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No. No**14. Where did the accident happen?**1 At home (inside house)2 At home (adjacent premises)3 Street and highway (includes roadway and public sidewalk)4 Farm5 Industrial place (includes premises) (Specify) _____6 School (includes premises)7 Place of recreation and sports, except at school8 Other (Specify)

Mark box if under 18.

 Under 18 (16)**15a. Was -- under 18 when the accident happened?**1 Yes (16) No**b. Was -- in the Armed Forces when the accident happened?**2 Yes (16) No**c. Was -- at work at -- job or business when the accident happened?**3 Yes4 No**16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?**1 Yes2 No (17)**b. Was more than one vehicle involved?**1 Yes2 No**c. Was [it/either one] moving at the time?**1 Yes2 No**17a. At the time of the accident what part of the body was hurt? What kind of injury was it?**

Anything else?

Part(s) of body *	Kind of injury

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

b. What part of the body is affected now?

How is -- (part of body) affected?

Is -- affected in any other way?

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

Ask probes as necessary. Record responses in 3c:

- 1 Yes (Probe, then 5) **(How did the accident happen?)**
 2 No **(What was -- doing at the time of the injury?)**

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

- Infection Sore Soreness

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

(Specify) _____

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

- Tumor Cyst Growth

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

- 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?

- Yes No (K2)

b. During that period, how many days did -- cut down for more than half of the day?

00 None (K2) _____ Days

7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?

00 None _____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?

00 None _____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?

00 None _____ Days

K2

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

10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)

000 None _____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?

- 1 Yes 2 No

K3

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

12a. Does -- still have this condition?

- 1 Yes (K4) 2 No

b. Is this condition completely cured or is it under control?

- 2 Cured 8 Other (Specify)
 3 Under control (K4)

_____ (K4)

c. About how long did -- have this condition before it was cured?

000 Less than 1 month OR _____ Number 1 Months 2 Years

d. Was this condition present at any time during the past 12 months?

- 1 Yes 2 No

K4

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

13. Is this (condition in 3b) the result of the same accident you already told me about?

- Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No.
 No

14. Where did the accident happen?

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

Mark box if under 18. Under 18 (16)

15a. Was -- under 18 when the accident happened?

- 1 Yes (16) No

b. Was -- in the Armed Forces when the accident happened?

- 2 Yes (16) No

c. Was -- at work at -- job or business when the accident happened?

- 3 Yes 4 No

16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?

- 1 Yes 2 No (17)

b. Was more than one vehicle involved?

- 1 Yes 2 No

c. Was [it/either one] moving at the time?

- 1 Yes 2 No

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

Part(s) of body *	Kind of injury

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

b. What part of the body is affected now?

How is -- (part of body) affected? Is -- affected in any other way?

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

1. Name of condition

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

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

- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. reference period | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- } (3b)

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy (5) | 4 <input type="checkbox"/> Old age (NC) |
| | 8 <input type="checkbox"/> Other (3c) |

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

Mark box if accident or injury. 0 Accident/injury (Probe, then 5)

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

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

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

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

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

(Specify)

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

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

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

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

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

g. What part of the body is affected? _____

(Specify)

Show the following detail:

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

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

- Infection Sore Soreness**

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

(Specify) _____

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

- Tumor Cyst Growth**

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

- 1 Malignant 2 Benign 9 DK

5.

a. When was -- (condition in 3b/3f) first noticed?

- 1 2-wk. ref. pd.
 2 Over 2 weeks to 3 months
 3 Over 3 months to 1 year
 4 Over 1 year to 5 years
 5 Over 5 years

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

- 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does?

- Yes No (K2)

b. During that period, how many days did -- cut down for more than half of the day?

- 00 None (K2) _____ Days

7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition?

- 00 None _____ Days

Ask if "Wa/Wb" box marked in C1:

8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?

- 00 None _____ Days

Ask if age 5-17:

9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?

- 00 None _____ Days

K2

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

10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.)

- 000 None _____ Days

11. Was -- ever hospitalized for -- (condition in 3b)?

- 1 Yes ,2 No

K3

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

12a. Does -- still have this condition?

- 1 Yes (K4) 2 No

b. Is this condition completely cured or is it under control?

- 2 Cured 8 Other (Specify)
 3 Under control (K4)

(K4)

c. About how long did -- have this condition before it was cured?

- 000 Less than 1 month OR _____ Number $\left\{ \begin{array}{l} 1 \text{ Months} \\ 2 \text{ Years} \end{array} \right.$

d. Was this condition present at any time during the past 12 months?

- 1 Yes 2 No

K4

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

13. Is this (condition in 3b) the result of the same accident you already told me about?

- Yes (Record condition page number where accident questions first completed.) → _____ Page No. (NC)
 No

14. Where did the accident happen?

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

Mark box if under 18. Under 18 (16)

15a. Was -- under 18 when the accident happened?

- 1 Yes (16) No

b. Was -- in the Armed Forces when the accident happened?

- 2 Yes (16) No

c. Was -- at work at -- job or business when the accident happened?

- 3 Yes 4 No

16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?

- 1 Yes 2 No (17)

b. Was more than one vehicle involved?

- 1 Yes 2 No

c. Was [it/either one] moving at the time?

- 1 Yes 2 No

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

Part(s) of body *	Kind of injury

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

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

Part(s) of body *	Present effects **

* Enter part of body in same detail as for 3g.

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

L. DEMOGRAPHIC BACKGROUND PAGE

L1	<i>Refer to age.</i>	L1	<input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)																										
1a. Did -- EVER serve on active duty in the Armed Forces of the United States? <hr style="border-top: 1px dashed black;"/> b. When did -- serve? <i>Mark box in descending order of priority. Thus, if person served in Vietnam and in Korea mark VN.</i> <table style="margin-left: 20px; border-left: 1px solid black; border-right: 1px solid black; padding: 0 10px;"> <tr><td>Vietnam Era (Aug. '64 to April '75)</td><td>.....</td><td>VN</td></tr> <tr><td>Korean War (June '50 to Jan. '55)</td><td>.....</td><td>KW</td></tr> <tr><td>World War II (Sept. '40 to July '47)</td><td>.....</td><td>WWII</td></tr> <tr><td>World War I (April '17 to Nov. '18)</td><td>.....</td><td>WWI</td></tr> <tr><td>Post Vietnam (May '75 to present)</td><td>.....</td><td>PVN</td></tr> <tr><td>Other Service (all other periods)</td><td>.....</td><td>OS</td></tr> </table>		Vietnam Era (Aug. '64 to April '75)	VN	Korean War (June '50 to Jan. '55)	KW	World War II (Sept. '40 to July '47)	WWII	World War I (April '17 to Nov. '18)	WWI	Post Vietnam (May '75 to present)	PVN	Other Service (all other periods)	OS	1a. 1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (2) <hr style="border-top: 1px dashed black;"/> b. <table style="width: 100%;"> <tr><td>1 <input type="checkbox"/> VN</td><td>5 <input type="checkbox"/> PVN</td></tr> <tr><td>2 <input type="checkbox"/> KW</td><td>8 <input type="checkbox"/> OS</td></tr> <tr><td>3 <input type="checkbox"/> WWII</td><td>9 <input type="checkbox"/> DK</td></tr> <tr><td>4 <input type="checkbox"/> WWI</td><td></td></tr> </table>		1 <input type="checkbox"/> VN	5 <input type="checkbox"/> PVN	2 <input type="checkbox"/> KW	8 <input type="checkbox"/> OS	3 <input type="checkbox"/> WWII	9 <input type="checkbox"/> DK	4 <input type="checkbox"/> WWI	
Vietnam Era (Aug. '64 to April '75)	VN																											
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Post Vietnam (May '75 to present)	PVN																											
Other Service (all other periods)	OS																											
1 <input type="checkbox"/> VN	5 <input type="checkbox"/> PVN																												
2 <input type="checkbox"/> KW	8 <input type="checkbox"/> OS																												
3 <input type="checkbox"/> WWII	9 <input type="checkbox"/> DK																												
4 <input type="checkbox"/> WWI																													
c. Was -- EVER an active member of a National Guard or military reserve unit? <hr style="border-top: 1px dashed black;"/> d. Was ALL of -- active duty service related to National Guard or military reserve training?		c. <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2) <hr style="border-top: 1px dashed black;"/> d. <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK																											
2a. What is the highest grade or year of regular school -- has ever attended? <hr style="border-top: 1px dashed black;"/> b. Did -- finish the (number in 2a) [grade/year]?		2a. 00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+ <hr style="border-top: 1px dashed black;"/> b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											

FOOTNOTES

L1	<input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)	<input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)	L1	<input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)	<input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)
1a.	1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (2)	1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (2)	1a.	1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (2)	1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (2)
b.	1 <input type="checkbox"/> VN 5 <input type="checkbox"/> PVN 2 <input type="checkbox"/> KW 8 <input type="checkbox"/> OS 3 <input type="checkbox"/> WWII 9 <input type="checkbox"/> DK 4 <input type="checkbox"/> WWI	1 <input type="checkbox"/> VN 5 <input type="checkbox"/> PVN 2 <input type="checkbox"/> KW 8 <input type="checkbox"/> OS 3 <input type="checkbox"/> WWII 9 <input type="checkbox"/> DK 4 <input type="checkbox"/> WWI	b.	1 <input type="checkbox"/> VN 5 <input type="checkbox"/> PVN 2 <input type="checkbox"/> KW 8 <input type="checkbox"/> OS 3 <input type="checkbox"/> WWII 9 <input type="checkbox"/> DK 4 <input type="checkbox"/> WWI	1 <input type="checkbox"/> VN 5 <input type="checkbox"/> PVN 2 <input type="checkbox"/> KW 8 <input type="checkbox"/> OS 3 <input type="checkbox"/> WWII 9 <input type="checkbox"/> DK 4 <input type="checkbox"/> WWI
c.	<input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)	<input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)	c.	<input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)	<input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)
d.	1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	d.	1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
2a.	00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+	00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+	2a.	00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+	00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+
b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

FOOTNOTES

L2	0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)	0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)	L2	0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)	0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)
5a.	1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)	1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)	5a.	1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)	1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)
b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
c.	1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)	1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)	c.	1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)	1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)
6b. and c.	Employer <input type="checkbox"/> NEV (6g) <input type="checkbox"/> AF (6e)	Employer <input type="checkbox"/> NEV (6g) <input type="checkbox"/> AF (6e)	6b. and c.	Employer <input type="checkbox"/> NEV (6g) <input type="checkbox"/> AF (6e)	Employer <input type="checkbox"/> NEV (6g) <input type="checkbox"/> AF (6e)
d.	Industry	Industry	d.	Industry	Industry
e.	Occupation <input type="checkbox"/> AF (NP)	Occupation <input type="checkbox"/> AF (NP)	e.	Occupation <input type="checkbox"/> AF (NP)	Occupation <input type="checkbox"/> AF (NP)
f.	Duties	Duties	f.	Duties	Duties
g.	Class of worker 1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV	Class of worker 1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV	g.	Class of worker 1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV	Class of worker 1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

Mark box if under 14. If "Married" refer to household composition and mark accordingly.

7. Is -- now married, widowed, divorced, separated, or has -- never been married?

7.

- 0 Under 14
- 1 Married — spouse in HH
- 2 Married — spouse not in HH
- 3 Widowed
- 4 Divorced
- 5 Separated
- 6 Never married

8a. Was the total combined FAMILY income during the past 12 months — that is, yours, (read names, including Armed Forces members living at home) more or less than \$20,000? Include money from jobs, social security, retirement income, unemployment payments, public assistance, and so forth. Also include income from interest, dividends, net income from business, farm, or rent, and any other money income received.

Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.

Read parenthetical phrase if Armed Forces member living at home or if necessary.

b. Of those income groups, which letter best represents the total combined FAMILY income during the past 12 months (that is, yours, (read names, including Armed Forces members living at home))? Include wages, salaries, and other items we just talked about.

Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.

8a.

- 1 \$20,000 or more (Hand Card I)
- 2 Less than \$20,000 (Hand Card J)

b.

- | | | |
|-------------------------------|-------------------------------|--------------------------------|
| 00 <input type="checkbox"/> A | 10 <input type="checkbox"/> K | 20 <input type="checkbox"/> U |
| 01 <input type="checkbox"/> B | 11 <input type="checkbox"/> L | 21 <input type="checkbox"/> V |
| 02 <input type="checkbox"/> C | 12 <input type="checkbox"/> M | 22 <input type="checkbox"/> W |
| 03 <input type="checkbox"/> D | 13 <input type="checkbox"/> N | 23 <input type="checkbox"/> X |
| 04 <input type="checkbox"/> E | 14 <input type="checkbox"/> O | 24 <input type="checkbox"/> Y |
| 05 <input type="checkbox"/> F | 15 <input type="checkbox"/> P | 25 <input type="checkbox"/> Z |
| 06 <input type="checkbox"/> G | 16 <input type="checkbox"/> Q | 26 <input type="checkbox"/> ZZ |
| 07 <input type="checkbox"/> H | 17 <input type="checkbox"/> R | |
| 08 <input type="checkbox"/> I | 18 <input type="checkbox"/> S | |
| 09 <input type="checkbox"/> J | 19 <input type="checkbox"/> T | |

R

a. Mark first appropriate box.

b. Enter person number of respondent.

Ra.

- 1 Present for all questions
- 2 Present for some questions
- 3 Not present

b.

 Person number(s) of respondent(s)

L3

Enter person number of first parent listed or mark box.

L3

 Person number of parent
 00 None in household

L4

Enter person number of spouse or mark box.

L4

 Person number of spouse
 00 None in household

FOOTNOTES

7.	0 <input type="checkbox"/> Under 14 1 <input type="checkbox"/> Married — spouse in HH 2 <input type="checkbox"/> Married — spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married	0 <input type="checkbox"/> Under 14 1 <input type="checkbox"/> Married — spouse in HH 2 <input type="checkbox"/> Married — spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married	7.	0 <input type="checkbox"/> Under 14 1 <input type="checkbox"/> Married — spouse in HH 2 <input type="checkbox"/> Married — spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married
Ra.	1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present	1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present	Ra.	1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present
b.	_____ Person number(s) of respondent(s)	_____ Person number(s) of respondent(s)	b.	_____ Person number(s) of respondent(s)
L3	_____ Person number of parent 00 <input type="checkbox"/> None in household	_____ Person number of parent 00 <input type="checkbox"/> None in household	L3	_____ Person number of parent 00 <input type="checkbox"/> None in household
L4	_____ Person number of spouse 00 <input type="checkbox"/> None in household	_____ Person number of spouse 00 <input type="checkbox"/> None in household	L4	_____ Person number of spouse 00 <input type="checkbox"/> None in household

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

RT 61

3-4

L5

Read to respondent: **In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics.**

L6

Enter date of birth from question 3 on Household Composition page.

L6

Date of birth **5-11**

Month	Date	Year

9a. In what State or country was -- born?

Print the full name of the State or mark the appropriate box if the person was not born in the United States.

9a.

12-13

99 DK (L7)

_____ State

01 Puerto Rico 05 Cuba
 02 Virgin Islands 06 Mexico
 03 Guam 98 All other countries
 04 Canada

If born in U.S., ask 9b only; if born in foreign country, ask 9c only.

b. Altogether, how many years has -- lived in (State of present residence)?

b.

14

1 Less than 1 yr.
 2 1 yr., less than 5
 3 5 yrs., less than 10
 4 10 yrs., less than 15
 5 15 yrs. or more
 9 DK

c. Altogether, how many years has -- lived in the United States?

c.

15

1 Less than 1 yr.
 2 1 yr., less than 5
 3 5 yrs., less than 10
 4 10 yrs., less than 15
 5 15 yrs. or more
 9 DK

L7

Print full name, including middle initial, from question 1 on Household Composition page.

L7

Last **16-35**

First **36-50**

Middle initial **51**

Verify for males; ask for females.

10. What is -- father's LAST name? Verify spelling. DO NOT write "Same".

10.

Father's LAST name **52-71**

Read to respondent: **We also need -- Social Security Number to link with vital statistics and other records of the Department of Health and Human Services to perform health-related research. Providing this information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on -- benefits if you do provide it and this number will not be given to any other government or nongovernment agency.**

11.

72-80

99999999 DK

□ □ □ - □ □ - □ □ □ □ □ □

Social Security Number

Read if necessary: **The Public Health Service Act is title 42, United States Code, Section 242k.**

11. What is -- Social Security Number?

11.

Mark if number obtained from **81**

0 Does not have SSN 2 Records
 1 Memory 7 Refused

L8

Mark box to indicate how Social Security number was or was not obtained.

L8

82

1 Self-personal
 2 Self-telephone
 3 Proxy-personal
 4 Proxy-telephone

		RT 61 3-4			RT 61 3-4			RT 61 3-4			RT 61 3-4	
L6	Date of birth	5-11			Date of birth	5-11			Date of birth	5-11		
	Month	Date	Year		Month	Date	Year		Month	Date	Year	
9a.	99 <input type="checkbox"/> DK (L7)	12-13			99 <input type="checkbox"/> DK (L7)	12-13			99 <input type="checkbox"/> DK (L7)	12-13		
	State	State			State	State			State	State		
	01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba	01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba	01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba	01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba	01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba	01 <input type="checkbox"/> Puerto Rico	05 <input type="checkbox"/> Cuba
	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico	02 <input type="checkbox"/> Virgin Islands	06 <input type="checkbox"/> Mexico
	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries	03 <input type="checkbox"/> Guam	98 <input type="checkbox"/> All other countries
	04 <input type="checkbox"/> Canada		04 <input type="checkbox"/> Canada		04 <input type="checkbox"/> Canada		04 <input type="checkbox"/> Canada		04 <input type="checkbox"/> Canada		04 <input type="checkbox"/> Canada	
b.	1 <input type="checkbox"/> Less than 1 yr.	14			1 <input type="checkbox"/> Less than 1 yr.	14			1 <input type="checkbox"/> Less than 1 yr.	14		
	2 <input type="checkbox"/> 1 yr., less than 5				2 <input type="checkbox"/> 1 yr., less than 5				2 <input type="checkbox"/> 1 yr., less than 5			
	3 <input type="checkbox"/> 5 yrs., less than 10				3 <input type="checkbox"/> 5 yrs., less than 10				3 <input type="checkbox"/> 5 yrs., less than 10			
	4 <input type="checkbox"/> 10 yrs., less than 15				4 <input type="checkbox"/> 10 yrs., less than 15				4 <input type="checkbox"/> 10 yrs., less than 15			
	5 <input type="checkbox"/> 15 yrs. or more				5 <input type="checkbox"/> 15 yrs. or more				5 <input type="checkbox"/> 15 yrs. or more			
	9 <input type="checkbox"/> DK				9 <input type="checkbox"/> DK				9 <input type="checkbox"/> DK			
c.	1 <input type="checkbox"/> Less than 1 yr.	15			1 <input type="checkbox"/> Less than 1 yr.	15			1 <input type="checkbox"/> Less than 1 yr.	15		
	2 <input type="checkbox"/> 1 yr., less than 5				2 <input type="checkbox"/> 1 yr., less than 5				2 <input type="checkbox"/> 1 yr., less than 5			
	3 <input type="checkbox"/> 5 yrs., less than 10				3 <input type="checkbox"/> 5 yrs., less than 10				3 <input type="checkbox"/> 5 yrs., less than 10			
	4 <input type="checkbox"/> 10 yrs., less than 15				4 <input type="checkbox"/> 10 yrs., less than 15				4 <input type="checkbox"/> 10 yrs., less than 15			
	5 <input type="checkbox"/> 15 yrs. or more				5 <input type="checkbox"/> 15 yrs. or more				5 <input type="checkbox"/> 15 yrs. or more			
	9 <input type="checkbox"/> DK				9 <input type="checkbox"/> DK				9 <input type="checkbox"/> DK			
L7	Last	16-35			Last	16-35			Last	16-35		
	First	36-50			First	36-50			First	36-50		
	Middle initial	51			Middle initial	51			Middle initial	51		
10.	Father's LAST name	52-71			Father's LAST name	52-71			Father's LAST name	52-71		
11.	999999999 <input type="checkbox"/> DK	72-80			999999999 <input type="checkbox"/> DK	72-80			999999999 <input type="checkbox"/> DK	72-80		
	<div style="display: flex; justify-content: space-between;"> [][] - [][] - [][][][][] [][] - [][] - [][][][][] </div> Social Security Number				<div style="display: flex; justify-content: space-between;"> [][] - [][] - [][][][][] [][] - [][] - [][][][][] </div> Social Security Number				<div style="display: flex; justify-content: space-between;"> [][] - [][] - [][][][][] [][] - [][] - [][][][][] </div> Social Security Number			
	Mark if number obtained from <input checked="" type="checkbox"/>	81			Mark if number obtained from <input checked="" type="checkbox"/>	81			Mark if number obtained from <input checked="" type="checkbox"/>	81		
	0 <input type="checkbox"/> Does not have SSN	2 <input type="checkbox"/> Records	0 <input type="checkbox"/> Does not have SSN	2 <input type="checkbox"/> Records	0 <input type="checkbox"/> Does not have SSN	2 <input type="checkbox"/> Records	0 <input type="checkbox"/> Does not have SSN	2 <input type="checkbox"/> Records	0 <input type="checkbox"/> Does not have SSN	2 <input type="checkbox"/> Records	0 <input type="checkbox"/> Does not have SSN	2 <input type="checkbox"/> Records
	1 <input type="checkbox"/> Memory	7 <input type="checkbox"/> Refused	1 <input type="checkbox"/> Memory	7 <input type="checkbox"/> Refused	1 <input type="checkbox"/> Memory	7 <input type="checkbox"/> Refused	1 <input type="checkbox"/> Memory	7 <input type="checkbox"/> Refused	1 <input type="checkbox"/> Memory	7 <input type="checkbox"/> Refused	1 <input type="checkbox"/> Memory	7 <input type="checkbox"/> Refused
L8	1 <input type="checkbox"/> Self-personal	82			1 <input type="checkbox"/> Self-personal	82			1 <input type="checkbox"/> Self-personal	82		
	2 <input type="checkbox"/> Self-telephone				2 <input type="checkbox"/> Self-telephone				2 <input type="checkbox"/> Self-telephone			
	3 <input type="checkbox"/> Proxy-personal				3 <input type="checkbox"/> Proxy-personal				3 <input type="checkbox"/> Proxy-personal			
	4 <input type="checkbox"/> Proxy-telephone				4 <input type="checkbox"/> Proxy-telephone				4 <input type="checkbox"/> Proxy-telephone			

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

Read to hhd. respondent: **The National Center for Health Statistics may wish to contact you again to obtain additional health related information. Please give me the name, address, and telephone number of a relative or friend who would know where you could be reached in case we have trouble reaching you. (Please give me the name of someone who is not currently living in the household.) Please print items 12-16.**

12. Contact Person name, Last	3-4 5-24	First	25-39	Middle initial	40	14. Area code/telephone number <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> - <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK	RT 62 97-106
13a. Address (Number and street)						41-65	107
b. City	66-85	State	86-87	ZIP Code	88-96	15. Relationship to household respondent	108-109

16. If you must be contacted again, what is the best time to call or visit?

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

17. During the past 12 months, has your household been without telephone service for more than one week?

If no phone, mark "Yes".

- 1 Yes (18)
 2 No
 9 DK } (Item L9)

110

18. For how long was your household without telephone service in the past 12 months?

- 0123 Entire 12 months
 0000 One week or less

 (Number)

- { 1 Day(s)
 2 Week(s)
 3 Month(s)

- 9999 DK

111-114

L9

Refer to question 3 on the Household Composition page.

- Any children under 6 years old (Go to HIS-2)
 Other (Skip to HIS-3)

FOOTNOTES

TABLE X - DETERMINING IF AN ADDITIONAL LIVING QUARTERS QUALIFIES AS AN EXTRA UNIT

ADDRESS OF ADDITIONAL LIVING QUARTERS	AREA SEGMENT		PERMIT SEGMENT	SEPARATENESS		NUMBER OF EXTRA UNITS
<p><i>Check the listing sheet.</i></p> <p>Is the address already listed?</p> <p style="text-align: center;">(1)</p>	<p>Are the additional living quarters within the area segment boundaries?</p> <p style="text-align: center;">(2)</p>	<p>Are the additional living quarters in a Group Quarters (GQ)?</p> <p style="text-align: center;">(3)</p>	<p>Are the additional living quarters within the same structure and within the same space ^{1/} occupied by the original sample unit?</p> <p style="text-align: center;">(4)</p>	<p>Do the occupants or intended occupants of the additional living quarters live and eat separately from all other persons on the property?</p> <p style="text-align: center;">(5)</p>	<p>Do the occupants or intended occupants of the additional living quarters have direct access from the outside or through a common hall?</p> <p style="text-align: center;">(6)</p>	<p>Have you found more than 3 EXTRA units?</p> <p style="text-align: center;">(7)</p>
<p><input type="checkbox"/> Yes - Enter sheet and line no.: Stop Table X } Sheet _____ Line _____</p> <p><input type="checkbox"/> No - Enter address or description, then go to column (2) or (4) depending on Seg.</p> <p>_____</p>	<p><input type="checkbox"/> Yes - Go to column (3)</p> <p><input type="checkbox"/> No - Do not interview</p>	<p><input type="checkbox"/> Yes - Do not interview</p> <p><input type="checkbox"/> No - Skip to column (5)</p>	<p><input type="checkbox"/> Yes - Go to column (5)</p> <p><input type="checkbox"/> No - Do not interview</p>	<p><input type="checkbox"/> Yes - Go to column (6)</p> <p><input type="checkbox"/> No - Not a separate unit. Stop Table X. Include quarters with original unit.</p>	<p><input type="checkbox"/> Yes - An EXTRA unit. Go to column (7)</p> <p><input type="checkbox"/> No - Not a separate unit. Stop Table X. Include quarters with original unit.</p>	<p><input type="checkbox"/> Yes - Call your office for instructions on which units to interview. ^{2/}</p> <p><input type="checkbox"/> No - Enter address on listing sheet. Interview parent and EXTRA units.</p>
<p><input type="checkbox"/> Yes - Enter sheet and line no.: Stop Table X } Sheet _____ Line _____</p> <p><input type="checkbox"/> No - Enter address or description, then go to column (2) or (4) depending on Seg.</p> <p>_____</p>	<p><input type="checkbox"/> Yes - Go to column (3)</p> <p><input type="checkbox"/> No - Do not interview</p>	<p><input type="checkbox"/> Yes - Do not interview</p> <p><input type="checkbox"/> No - Skip to column (5)</p>	<p><input type="checkbox"/> Yes - Go to column (5)</p> <p><input type="checkbox"/> No - Do not interview</p>	<p><input type="checkbox"/> Yes - Go to column (6)</p> <p><input type="checkbox"/> No - Not a separate unit. Stop Table X. Include quarters with original unit.</p>	<p><input type="checkbox"/> Yes - An EXTRA unit. Go to column (7)</p> <p><input type="checkbox"/> No - Not a separate unit. Stop Table X. Include quarters with original unit.</p>	<p><input type="checkbox"/> Yes - Call your office for instructions on which units to interview. ^{2/}</p> <p><input type="checkbox"/> No - Enter address on listing sheet. Interview parent and EXTRA units.</p>
<p><input type="checkbox"/> Yes - Enter sheet and line no.: Stop Table X } Sheet _____ Line _____</p> <p><input type="checkbox"/> No - Enter address or description, then go to column (2) or (4) depending on Seg.</p> <p>_____</p>	<p><input type="checkbox"/> Yes - Go to column (3)</p> <p><input type="checkbox"/> No - Do not interview</p>	<p><input type="checkbox"/> Yes - Do not interview</p> <p><input type="checkbox"/> No - Skip to column (5)</p>	<p><input type="checkbox"/> Yes - Go to column (5)</p> <p><input type="checkbox"/> No - Do not interview</p>	<p><input type="checkbox"/> Yes - Go to column (6)</p> <p><input type="checkbox"/> No - Not a separate unit. Stop Table X. Include quarters with original unit.</p>	<p><input type="checkbox"/> Yes - An EXTRA unit. Go to column (7)</p> <p><input type="checkbox"/> No - Not a separate unit. Stop Table X. Include quarters with original unit.</p>	<p><input type="checkbox"/> Yes - Call your office for instructions on which units to interview. ^{2/}</p> <p><input type="checkbox"/> No - Enter address on listing sheet. Interview parent and EXTRA units.</p>

^{1/} Occupation of the same space occurs if a housing unit has been split into two or more separate housing units.

^{2/} When your RO has determined which units to interview, enter the addresses on the listing sheets and proceed with the interviews.

FOOTNOTES