

Plan and Operation of the Health and Nutrition Examination Survey United States-1971-1973

A description of a national health and nutrition examination survey of a probability sample of the U.S. population 1-74 years of age:

Part A-Development, plan, and operation.

Part B-Data collection forms of the survey.

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National Center for Health Statistics
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APPENDIX IIA. HANES HOUSEHOLD QUESTIONNAIRE

NOTICE - All information which would permit identification of the individual will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.					O.M.B. NO. 68-R1184 APPROVAL EXPIRES DECEMBER 31, 1973										
FORM HES-5 (CYCLE IV) (10-571) U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE U.S. PUBLIC HEALTH SERVICE HEALTH EXAMINATION SURVEY		1. Stand No.	2. Identification code	3. PSU No.	4. Segment No.	5. Serial No.	6. Questionnaire _____ of _____ questionnaires								
7. Address or description of location (No. and St., City, State, ZIP code) _____ City _____ State _____ ZIP code _____			Listing Sheet No. _____ Sheet No. _____ Line No. _____	8. Year built - If "Ask" box is "X'd", complete this item before the interview <input type="checkbox"/> Ask <input type="checkbox"/> Do not ask When was this structure originally built? <input type="checkbox"/> Before 4-1-60 <input type="checkbox"/> After 4-1-60 - Go to Q. 12c, complete if required and end interview											
9. Is -- your correct mailing address? <input type="checkbox"/> Yes <input type="checkbox"/> No (What is your correct mailing address?) _____ City _____ State _____ ZIP code _____			If this questionnaire is for an "EXTRA" unit in "B" or NTA Segment, enter: <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <tr> <td style="width: 25%;">Serial number of original Sample Unit</td> <td style="width: 25%;">Item number by which found</td> <td style="width: 25%;">Listing Sheet (If in NTA Segment, also enter for FIRST unit listed on property)</td> <td style="width: 25%;">Listing Sheet</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td>Sheet No. _____ Line No. _____</td> </tr> </table>					Serial number of original Sample Unit	Item number by which found	Listing Sheet (If in NTA Segment, also enter for FIRST unit listed on property)	Listing Sheet				Sheet No. _____ Line No. _____
Serial number of original Sample Unit	Item number by which found	Listing Sheet (If in NTA Segment, also enter for FIRST unit listed on property)	Listing Sheet												
			Sheet No. _____ Line No. _____												
10. Type of living quarters Mark one box <input type="checkbox"/> 1 Housing unit <input type="checkbox"/> 2 Other unit			11. Special place name _____ Type _____ Type code _____												
12. Ask: <input type="checkbox"/> a. Are there any occupied or vacant living quarters besides your own in this building? <input type="checkbox"/> Yes (fill Table X) <input type="checkbox"/> No <input type="checkbox"/> b. Are there any occupied or vacant living quarters besides your own on this floor? <input type="checkbox"/> Yes (fill Table X) <input type="checkbox"/> No <input type="checkbox"/> c. Is there any other building on this property for people to live in - either occupied or vacant? <input type="checkbox"/> Yes (fill Table X) <input type="checkbox"/> No <input type="checkbox"/> d. None (item L)			15. What is the telephone number here? <input type="checkbox"/> None												
ITEM L <input type="checkbox"/> 2 Rural (13) <input type="checkbox"/> 1 All other (Q. 1, p. 2)			16. INTERVIEWER (Ask only for households with EP's) The information you have just given me will be used by the Public Health Service to determine which persons will be asked to participate in the other part of this survey. That part will cover health and nutrition. If anyone in your household is selected, a representative of the U.S. Public Health Service will be calling on you within a week or so to explain the second part. What would be the best time for her to visit you -- morning or afternoon? Day _____ Time _____ a.m. p.m. Name of respondent _____ LEAVE THANK YOU LETTER												
13. Do you own or rent this place? <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Rent free			14a. How many acres of land are included? <input type="checkbox"/> 1 10 or more acres (b) <input type="checkbox"/> 2 Less than 10 acres (c) b. During the past 12 months did sales of crops, livestock, and other farm products from the place amount to \$50 or more? <input type="checkbox"/> 2 Yes (Q. 1, p. 2) <input type="checkbox"/> 4 No (Q. 1, p. 2) c. During the past 12 months did sales of crops, livestock, and other farm products from the place amount to \$250 or more? <input type="checkbox"/> 3 Yes (Q. 1, p. 2) <input type="checkbox"/> 5 No (Q. 1, p. 2)												
17. RECORD OF CALLS AT HOUSEHOLD															
Date	1	Com.	2	Com.	3	Com.	4	Com.	5	Com.	6	Com.			
Time	a.m. p.m.		a.m. p.m.		a.m. p.m.		a.m. p.m.		a.m. p.m.		a.m. p.m.				
18. REASON FOR NONINTERVIEW															
TYPE A (Complete items 1-14, 17-20) <input type="checkbox"/> Refusal - Describe in footnotes <input type="checkbox"/> No one at home - repeated calls <input type="checkbox"/> Temporarily absent <input type="checkbox"/> Other - Specify _____			TYPE B (Complete items 1-12, L, 14, 17, 18, and 20) <input type="checkbox"/> Vacant - non-seasonal <input type="checkbox"/> Vacant - seasonal <input type="checkbox"/> Usual residence elsewhere <input type="checkbox"/> Armed Forces <input type="checkbox"/> Other - Specify _____			TYPE C (Complete items 1-8, 11, 17, 18, and 20) <input type="checkbox"/> Demolished <input type="checkbox"/> In sample by mistake <input type="checkbox"/> Eliminated in sub-sample <input type="checkbox"/> Built after April 1, 1960 <input type="checkbox"/> Other - Specify _____			TYPE Z (Partial interview) Interview not obtained for: Person No. _____ because: _____						
19a. For "final" Type A noninterviews enter names, approximate ages, and sex of household members.						19b. Who supplied this information?									
Name	Age	Sex	Name	Age	Sex	Name									
1.			4.			Number and street, route, or box number									
2.			5.			City									
3.			6.			Code									
19c. Race <input type="checkbox"/> W <input type="checkbox"/> N <input type="checkbox"/> OT			20. Signature of interviewer _____						Code _____						
Footnotes															
WASHINGTON USE ONLY															
Total number of persons						Total number of sample persons									

<p>1a. What is the name of the head of this household? - Enter name in first column. Yes* No</p> <p>b. What are the names of all other persons who live here? - List all persons who live here.</p> <p>c. I have listed (Read names) Is there anyone else staying here now, such as friends, relatives, or roomers? <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Have I missed anyone who USUALLY lives here but is now away from home? <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Do any of the people in this household have a home anywhere else? <input type="checkbox"/> <input type="checkbox"/></p> <p>If any adult males listed, ask: * Apply household membership rules.</p> <p>f. Are any of the persons in this household now on full-time active duty with the Armed Forces of the United States? <input type="checkbox"/> Yes → Col(s). _____ (Delete) <input type="checkbox"/> No</p>		<p>1a. First name ①</p> <p>-----</p> <p>Last name</p>									
<p>2. How is -- related to -- (Head of household)?</p>		<p>Relationship</p> <p>HEAD</p>									
<p>3a. How old was -- on his last birthday? - Enter Age and circle Race and Sex.</p>		<table border="1"> <tr> <td>AGE</td> <td>RACE</td> <td>SEX</td> </tr> <tr> <td>1 W 2 N 3 O T</td> <td>1 M 2 F</td> <td></td> </tr> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> </table>	AGE	RACE	SEX	1 W 2 N 3 O T	1 M 2 F		Month	Day	Year
AGE	RACE	SEX									
1 W 2 N 3 O T	1 M 2 F										
Month	Day	Year									
<p>b. What is the month, day, and year of --'s birth? - Use card to check birth date and age for consistency.</p>		<p><input type="checkbox"/> 1-74 years (EP)</p>									
<p>C INTERVIEWER: Mark the box for each person age 1-74 years and CONTINUE DO NOT CONTINUE for persons under 1 or 75 years of age or over. If no EP, go to page 1, question 15.</p>											
<p>4. In what State was -- born? Enter the name of the State or foreign country.</p>		<p>State or foreign country</p>									
<p>Ask for all EP's 17 years old or over:</p> <p>5. Is -- now married, widowed, divorced, separated, or never married? - Mark one box for each EP.</p>		<p>1 <input type="checkbox"/> Under 17 4 <input type="checkbox"/> Nev. married</p> <p>2 <input type="checkbox"/> Married 5 <input type="checkbox"/> Divorced</p> <p>3 <input type="checkbox"/> Widowed 6 <input type="checkbox"/> Separated</p>									
<p>Ask for all EP's 6 years old or over.</p>	<p>6a. What is the highest grade or year of regular school -- has ever attended?</p> <p>b. Did -- finish the -- grade (year)?</p> <p>If 6-18 years, ask:</p> <p>c. Is -- attending school now?</p> <p>d. What is the name and location of the school -- goes to?</p>	<p>70 <input type="checkbox"/> None (NP)</p> <p>2 Elem 1 2 3 4 5 6 7 8</p> <p>3 High 1 2 3 4</p> <p>6a. 4 College 1 2 3 4 5+</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. 1 <input type="checkbox"/> Yes (6d) 2 <input type="checkbox"/> No (NP)</p> <p>d. Name and location</p>									
<p>Ask for children 3-5 years old.</p>	<p>7a. Has -- ever attended a school of any kind?</p> <p>b. What kind of school?</p>	<p>7a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <p>1 <input type="checkbox"/> Nursery 2 <input type="checkbox"/> Kindergarten</p> <p>3 <input type="checkbox"/> Other Specify _____</p>									
<p>Ask for all EP households.</p>	<p>8a. Is any language other than English frequently spoken here in this home? 1 <input type="checkbox"/> Yes (8b) 2 <input type="checkbox"/> No (9)</p> <p>b. What language(s)? Language(s) spoken _____</p>										
<p>If "Negro" (N in Q.3) do not ask - Mark Negro box.</p>	<p>9. Which of the groups on this card - (hand card) best describes your (your husband's; or --'s) MAIN ancestry or national origin? (Additional probe: What is your MAIN ancestry or national origin?)</p>	<p>9. Ancestry or national origin</p> <p><input type="checkbox"/> Negro</p>									
<p>Ask for all EP's 17 years old or over.</p>	<p>10a. What was -- doing MOST of the past THREE months - (for males): working or doing something else? (for females): keeping house, working, or doing something else?</p> <p>b. What was -- doing?</p> <p>c. Did -- work at a job or business AT ANY TIME during the past THREE months?</p> <p>d. When -- was working, did he work full time or part time?</p>	<p>10a. 1 <input type="checkbox"/> Working 2 <input type="checkbox"/> Keeping house (10a)</p> <p>3 <input type="checkbox"/> Something else (10b)</p> <p>b. 1 <input type="checkbox"/> Retired 2 <input type="checkbox"/> Student</p> <p>3 <input type="checkbox"/> Other - Specify _____</p> <p>c. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (11b)</p> <p>d. 1 <input type="checkbox"/> Full time 2 <input type="checkbox"/> Part time</p>									
	<p>11a. Did -- work at any time last week or the week before? (for females): not counting work around the house?</p> <p>b. Even though -- did not work during that time, does he have a job or business?</p> <p>c. Was he looking for work or on layoff from a job?</p> <p>d. Which - looking for work or on layoff from a job?</p>	<p>11a. 1 <input type="checkbox"/> Yes (12)</p> <p>2 <input type="checkbox"/> No (11b and c)</p> <p>b. 1 <input type="checkbox"/> Yes (11c) 2 <input type="checkbox"/> No (11c)</p> <p>c. 1 <input type="checkbox"/> Yes (11d) 2 <input type="checkbox"/> No (12)</p> <p>1 <input type="checkbox"/> Looking 3 <input type="checkbox"/> Both</p> <p>d. 2 <input type="checkbox"/> Layoff</p>									
	<p>Ask for all EP's with a "Yes" in 11a, b, or c. If "Yes" in 11c only, questions 12a through 12c apply to this EP's LAST full-time civilian job.</p> <p>12a. Who does (did) -- work for?</p> <p>b. What kind of business or industry is this?</p> <p>c. What kind of work is (was) -- doing?</p> <p>d. Class of worker</p> <p>Fill 12d from entries in 12a-12c, if not clear ask.</p> <p>If self-employed in "OWN" business and not a farm, ask:</p> <p>e. Is the business incorporated?</p>	<p>Employer</p> <p>12a. Business or industry <input type="checkbox"/></p> <p>Occupation <input type="checkbox"/></p> <p>d. 1 <input type="checkbox"/> Private paid (NP)</p> <p>2 <input type="checkbox"/> Gov. Federal (NP)</p> <p>3 <input type="checkbox"/> Gov. other (NP)</p> <p>4 <input type="checkbox"/> Own (12e)</p> <p>5 <input type="checkbox"/> Nonpaid (NP)</p> <p>6 <input type="checkbox"/> Never worked (NP)</p> <p>e. 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No (NP)</p>									

13. How many rooms are there in this house (these living quarters)? Count the kitchen but not the bathroom.		1	2	3	4	5
Circle number of rooms →		6	7	8	9	or more
14a. Is there piped water in this house (these living quarters)?		1	Yes		2	No (15a(2))
b. Is there both hot and cold piped water?		1	Yes		2	No
15a. Does this house (these living quarters) have the following kitchen facilities —		(1) A sink with piped water?		1	Yes 2 No	
		(2) A range or cook stove?		1	Yes 2 No	
		(3) A refrigerator?		1	Yes 2 No (16)	
If "Yes" to all three above, ask: b. Are these kitchen facilities used by anyone NOT living in this household?		1	Yes		2	No
16. Please look at this card — Which of these income groups represents yours, your —'s etc., total combined family income for the past 12 months, that is, since (date) a year ago? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rent from property and so forth.		Group 11 <input type="checkbox"/> A (17) 15 <input type="checkbox"/> E (17) 19 <input type="checkbox"/> I (p. J) 12 <input type="checkbox"/> B (17) 16 <input type="checkbox"/> F (17) 20 <input type="checkbox"/> J (p. J) 13 <input type="checkbox"/> C (17) 17 <input type="checkbox"/> G (17) 21 <input type="checkbox"/> K (p. J) 14 <input type="checkbox"/> D (17) 18 <input type="checkbox"/> H (p. J) 22 <input type="checkbox"/> L (p. J)				
If A—G is marked in question 16, ask:		1 <input type="checkbox"/> Yes — How much altogether before deductions?		Amount		
17. During the past 12 months, did you or any members of your family receive any money from wages or salaries?		2 <input type="checkbox"/> No		\$ _____		
18. During the past 12 months, did you or any members of your family receive any money from —		a. Social Security or Railroad Retirement?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		b. Welfare payments or other public assistance (such as aid to families with dependent children, old age assistance, or aid to the blind or totally disabled)?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		c. Unemployment compensation or workmen's compensation?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		d. Government employee pensions or private pensions?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		e. Dividends, interest, or rent?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		f. Net income from their own nonfarm business, professional practice, or partnership?		Net income		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		g. Net income from a farm? (Net after operating expenses. Include earnings as a tenant farmer or sharecropper. If farm lost money, write "Loss" above amount.)		Net income		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		h. Veterans payments?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		i. Alimony, child support, or contributions from persons not living in this household?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
		j. Any other income?		Amount		
		1 <input type="checkbox"/> Yes — How much altogether?		\$ _____		
		2 <input type="checkbox"/> No		\$ _____		
INTERVIEWER: Enter the sum of all money received from all sources in questions 17 and 18, and continue interview with question 15 on the household page.				Total amount		
				\$ _____		

TABLE X — LIVING QUARTERS DETERMINATIONS AT LISTED ADDRESS

Line No.	LOCATION OF UNIT	B SEGMENTS ONLY	USE OR CHARACTERISTICS	CLASSIFICATION	IF HU IN B SEGMENT ASK:						
					IF HU IN B SEGMENT ASK:	IF HU IN B SEGMENT ASK:					
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	
1		S — L —	Y N	Y N	Y (9) N	Y N	Y N	N	HU	O _t	
2		S — L —	Y N	Y N	Y (9) N	Y N	Y N	N	HU	O _t	
3		S — L —	Y N	Y N	Y (9) N	Y N	Y N	N	HU	O _t	

NOTE: Continue interview with next item of the Household Page.

APPENDIX IIB. FOOD PROGRAMS QUESTIONNAIRE

HSM-411-11 (PAGE 1) REV. 5/71 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY FOOD PROGRAMS QUESTIONNAIRE		Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).		
a. Name of respondent (Last, first, middle)	b. Deck No.	c. Segment No.	d. Serial No.	e. Column No.
	101	-----	-----	-----
FOR INTERVIEWER USE ONLY Mark appropriate box before going into household.		Not applicable (001) 1 <input type="checkbox"/> Items 1 and 2 not applicable by HES income and family size criteria - SKIP to 3a Applicable 2 <input type="checkbox"/> No program available - SKIP to 3a 3 <input type="checkbox"/> Food stamps available - Ask 1a 4 <input type="checkbox"/> Commodities available - SKIP to 2a		
1a. Are you certified to participate in the food stamp program?	1a.	(002) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 3a		
b. Are you buying food stamps now?	b.	(003) 1 <input type="checkbox"/> Yes, regularly 2 <input type="checkbox"/> Yes, occasionally } SKIP to 3a 3 <input type="checkbox"/> No - Ask c		
c. What is the MAIN reason you aren't participating in the program?	c.	(004) 1 <input type="checkbox"/> No need 2 <input type="checkbox"/> Not enough money at the time 3 <input type="checkbox"/> No transportation 4 <input type="checkbox"/> Pride 5 <input type="checkbox"/> Other - Specify _____ _____		
2a. Are you certified to participate in the commodity distribution program?	2a.	(005) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 3a		
b. Are you receiving commodity foods now for your family?	b.	(006) 1 <input type="checkbox"/> Yes, regularly 2 <input type="checkbox"/> Yes, occasionally } SKIP to 3a 3 <input type="checkbox"/> No - Ask c		
c. Why aren't you participating in the program?	c.	(007) 1 <input type="checkbox"/> No need 2 <input type="checkbox"/> No transportation 3 <input type="checkbox"/> Pride 4 <input type="checkbox"/> Other - Specify _____ _____		
Ask the following questions only in households where there are sample children or youths attending school.	First name	BEGIN NEW RECORD	Deck No.	Sample No.
			102	-----
3a. Is there a school lunch program at the school that . . . attends?	3a.	(001) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to d		
b. How many times a week does he usually participate?	b.	(002) ___ Times		
c. How much does he pay for his lunch per day?	c.	(003) ___ Cents		
d. Is there a special milk program at the school that . . . attends?	d.	(004) 1 <input type="checkbox"/> Yes - Ask e 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to f		
e. How many times a week does he usually participate?	e.	(005) ___ Times		
f. Is there a school breakfast program at the school that . . . attends?	f.	(006) 1 <input type="checkbox"/> Yes - Ask g and h 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } Go to next sample child		
g. How many times a week does he usually participate?	g.	(007) ___ Times		
h. How much does he pay for his breakfast per day?	h.	(008) ___ Cents		

The same questions are asked for any further sample children or youths attending school.

APPENDIX IIC. MEDICAL HISTORY QUESTIONNAIRE, AGES 1-5

HSM-411-3 (PAGE 1) DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY MEDICAL HISTORY QUESTIONNAIRE - AGES 1-5			Form Approved D.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (21 FR 1687).		
a. Child's name (Last, first, middle)		b. Deck No. 061	c. Sample No.	d. Segment No.	
e. Serial No.	f. Column No.	g. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	h. Age 0	i. Date of birth Month	Day Year
1. How much did . . . weigh when he was born?		1.	(001) -- Pounds -- Ounces 9999 <input type="checkbox"/> Don't know		
2. Was . . . born prematurely? (that is, early or not carried the full nine months)		2.	(002) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know		
3. How old was . . . 's mother when . . . was born?		3.	(003) -- Years old 99 <input type="checkbox"/> Don't know		
4a. How many children has . . . 's mother had?		4a.	(004) -- Children - If more than 1, Ask b 99 <input type="checkbox"/> Don't know - SKIP to 5		
b. How many were born before . . . ?		b.	(005) -- Children 99 <input type="checkbox"/> Don't know		
5. How many of . . . 's brothers and sisters weighed less than five and one half pounds at birth?		5.	(006) -- Brothers and sisters 99 <input type="checkbox"/> Don't know		
6. How much did . . . weigh when he was a year old?		6.	(007) -- Pounds 99 <input type="checkbox"/> Don't know		
7. How much did . . . weigh when he was two years old?		7.	(008) -- Pounds 98 <input type="checkbox"/> Not yet two 99 <input type="checkbox"/> Don't know		
8. How old was . . . when he got his first tooth?		8.	(009) -- Months 99 <input type="checkbox"/> Don't know		
9. How old was . . . when he first sat up by himself?		9.	(010) -- Months 98 <input type="checkbox"/> Doesn't sit up yet 99 <input type="checkbox"/> Don't know		
10. How old was . . . when he first walked by himself?		10.	(011) -- Months 98 <input type="checkbox"/> Doesn't walk yet 99 <input type="checkbox"/> Don't know		
11a. Was . . . breast fed at any time?		11a.	(012) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 12a		
b. How old was he when he stopped breast feeding?		b.	(013) -- Months 98 <input type="checkbox"/> Still breast fed 99 <input type="checkbox"/> Don't know		
12a. As a baby, was . . . at any time fed milk from a bottle?		12a.	(014) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 13		
b. What type of milk was used?		b.	Yes No Don't know (1) Whole cow's milk (1) (015) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> (2) Commercially prepared milk - Specify brand if known (2) (016) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> (3) A soy base formula (3) (017) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/> (4) Other - Specify (4) (018) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 9 <input type="checkbox"/>		
13. How old was . . . when he first started eating solid foods like cereal or fruit? <i>INTERVIEWER - Convert replies in weeks to nearest whole number of months.</i>		13.	(019) -- Months 99 <input type="checkbox"/> Don't know		
14. Has . . . had the following immunizations?		14.	Yes	No	Don't know
DPT (Diphtheria, whooping cough, and tetanus)		(020)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Polio		(021)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Smallpox		(022)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Measles		(023)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
German Measles		(024)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Mumps		(025)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Other, don't know what for		(026)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
15. Does or did . . . have any conditions he was born with that involved any of the following?		15.	Yes	No	Don't know
Heart		(027)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Eyes		(028)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Mouth or throat		(029)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Stomach or intestines		(030)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Kidneys or urinary system		(031)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Muscles, bones, or joints		(032)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Brain or nervous system		(033)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>

16a. Has . . . ever accidentally swallowed any medicine, pills or poison?	16a.	(034) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 17a
b. Did this result in any serious damage?	b.	(035) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 17a
c. What was it? _____		
17a. Has . . . ever had a bad accident?	17a.	(036) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 18a
b. Does he still have the effects of it?	b.	(037) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 18a
c. What are they? _____		
18a. Has . . . ever stayed overnight in a hospital?	18a.	(038) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 19
b. For what? _____		
c. Has . . . ever had an operation?	c.	(039) 1 <input type="checkbox"/> Yes - Ask d 2 <input type="checkbox"/> No - SKIP to 19
d. For what? _____		
19. Does . . . have any allergies?	19.	(040) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know
20a. How many times has . . . had pneumonia?	20a.	(041) ___ Times
b. Does he have it now?	b.	(042) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
21a. During the past six months how many colds has . . . had?	21a.	(043) ___ Colds
b. Does he have one now?	b.	(044) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
22a. During the past six months has . . . passed any worms?	a.	(045) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 23a
b. What type, tiny white or pencil-sized?	b.	(046) 1 <input type="checkbox"/> Tiny white 2 <input type="checkbox"/> Pencil-sized 3 <input type="checkbox"/> Both
23a. During the past six months how many times has . . . had diarrhea?	23a.	(047) ___ Times
b. Does he have it now?	b.	(048) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
24a. Does . . . ever eat dirt or clay, starch, paint or plaster, or any material that might be considered unusual?	24a.	(049) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 25
b. Which?	b.	Yes No
(1) Dirt or clay (1)	(1)	(050) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
(2) Starch (2)	(2)	(051) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
(3) Paint or plaster (3)	(3)	(052) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
(4) Other - Specify _____ (4)	(4)	(053) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
25. Does . . . have unusual trouble seeing at night or in the dark?	25.	(054) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know
Here are some questions about . . . 's mother:		
26a. How much does she weigh?	26a.	(055) ___ Pounds 999 <input type="checkbox"/> Don't know
b. How tall is she?	b.	(056) ___ Feet ___ inches 999 <input type="checkbox"/> Don't know
Here are some questions about . . . 's father:		
27a. How much does he weigh?	27a.	(057) ___ Pounds 999 <input type="checkbox"/> Don't know
b. How tall is he?	b.	(058) ___ Feet ___ inches 999 <input type="checkbox"/> Don't know
28a. Do you use iodized table salt?	28a.	(059) 1 <input type="checkbox"/> Yes } SKIP to 29a 2 <input type="checkbox"/> No } 9 <input type="checkbox"/> Don't know - Ask b
b. May I see your box of table salt?	b.	(060) 1 <input type="checkbox"/> Iodized 2 <input type="checkbox"/> Not iodized 3 <input type="checkbox"/> No box
29a. Name of respondent _____		
b. Respondent's relationship to child covered by this questionnaire	b.	(061) 1 <input type="checkbox"/> Mother 2 <input type="checkbox"/> Other

APPENDIX IID. MEDICAL HISTORY QUESTIONNAIRE, AGES 6-11

HSM 411-9 (PAGE 1) REV. 8/71			Form Approved O.M.B. No. 68-R1184		
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY			ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).		
MEDICAL HISTORY QUESTIONNAIRE - AGES 6-11					
a. Name (Last, first, middle)		b. Deck No.	c. Sample No.	d. Segment No.	
		071			
e. Serial No.	f. Column No.	g. Sex	h. Age	i. Date of birth	
		1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female		Month	Day Year
1. How much did . . . weigh when he was born?		1.	(001) -- Pounds -- Ounces 9999 <input type="checkbox"/> Don't know		
2. Was . . . born prematurely? (That is, early or not carried the full nine months)		2.	(002) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know		
3a. How many children has . . . 's mother had?		3a.	(003) -- Children - If more than 1, Ask b 99 <input type="checkbox"/> Don't know - SKIP to 4		
b. How many were born before . . . ?		b.	(004) -- Children 99 <input type="checkbox"/> Don't know		
4. How many of . . . 's brothers and sisters weighed less than five and one-half pounds at birth?		4.	(005) -- Brothers and sisters 99 <input type="checkbox"/> Don't know		
5. How much did . . . weigh when he was a year old?		5.	(006) -- Pounds 99 <input type="checkbox"/> Don't know		
6a. Was . . . breast fed at any time?		6a.	(007) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 7a		
b. How old was . . . when he stopped breast feeding?		b.	(008) -- Months 99 <input type="checkbox"/> Don't know		
7a. As a baby, was . . . at any time fed milk from a bottle?		7a.	(009) 1 <input type="checkbox"/> Yes - Ask 7b 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't know } SKIP to 8		
b. What type of milk was used?		b.	Yes	No	Don't know
(1) Whole cow's milk		(010)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
(2) Commercially prepared milk - Specify brand if known		(011)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
(3) A soy base formula		(012)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
(4) Other - Specify		(013)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
8. How old was . . . when he first started eating solid foods like cereal or fruit? INTERVIEWER: convert replies in weeks to nearest number of months.		8.	(014) -- Months 99 <input type="checkbox"/> Don't know		
9. Does or did . . . have any conditions he was born with that involved any of the following?		9.	Yes	No	Don't know
Heart		(015)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Eyes		(016)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Mouth or throat		(017)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Stomach or intestines		(018)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Kidneys or urinary system		(019)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Muscles, bones, or joints		(020)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>
Brain or nervous system		(021)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	9 <input type="checkbox"/>

10. Has . . . ever been treated for the following?	10.	Yes	No	Don't know
Anemia	(022)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Abnormal bleeding	(023)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Asthma	(024)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other allergies	(025)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Tuberculosis	(026)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Pneumonia	(027)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other chest or lung condition	(028)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Heart condition	(029)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Diabetes	(030)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Epilepsy or convulsions	(031)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Stomach or intestinal disorder (excluding diarrhea)	(032)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Kidney disease or infection	(033)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Thyroid disease or goiter	(034)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cancer or tumors	(035)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other conditions - Specify _____	(036)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

11a. Has . . . ever had a bad accident?	11a.	(037) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know	} SKIP to 12a	
b. Does he still have the effects of it?	b.	(038) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 12a		
c. What are they? _____				
12a. Has . . . ever stayed overnight in a hospital?	12a.	(039) 1 <input type="checkbox"/> Yes - Ask b and c 2 <input type="checkbox"/> No - SKIP to 13a		
b. For what? _____				
c. Has . . . ever had an operation?	c.	(040) 1 <input type="checkbox"/> Yes - Ask d 2 <input type="checkbox"/> No - SKIP to 13a		
d. For what? _____				
13a. Is . . . unable to do some things because of a condition that has bothered him for a long time?	13a.	(041) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 14a		
b. What can't he do? _____				
14a. During the past six months how many colds has . . . had?	14a.	(042) _____ Colds		
b. Does he have one now?	b.	(043) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
15a. During the past six months has . . . passed any worms?	15a.	(044) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know	} SKIP to 16a	
b. What type, tiny white or pencil-sized?	b.	(045) 1 <input type="checkbox"/> Tiny white 2 <input type="checkbox"/> Pencil-sized 3 <input type="checkbox"/> Both		
16a. During the past six months how many times has . . . had diarrhea?	16a.	(046) _____ Times		
b. Does he have it now?	b.	(047) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
17a. Does . . . ever eat dirt or clay, starch, paint or plaster, or any material that might be considered unusual?	17a.	(048) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP TO 18		
b. Which?	b.	Yes No		
Dirt or clay	(049)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Starch	(050)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Paint or plaster	(051)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Other - Specify _____	(052)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	

18. Does . . . have unusual trouble seeing at night or in the dark?	18.	(053) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know
19a. Has . . . ever had any other trouble seeing?	19a.	(054) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 20a
b. Was it because of either an eye injury, infection or other eye problem? (1) An eye injury	b.	(055) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) An eye infection or other eye problem . . .		(056) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - If "No" to both (1) and (2) SKIP to 20a
c. Did he see a doctor about it? (1) An eye injury	c.	(057) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
(2) An eye infection or other eye problem . . .		(058) 1 <input type="checkbox"/> Yes - Ask d 2 <input type="checkbox"/> No - If "No" to both (1) and (2) SKIP to 20a
d. What did he say the trouble was?		
20a. Has . . . ever had an eye accident or eye injury that did not affect his vision?	20a.	(059) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 21a
b. Did he see a doctor about it?	b.	(060) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
21a. Has . . . ever worn glasses or contact lenses?	21a.	(061) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 22
b. Does he still wear them?	b.	(062) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. When does (did) he wear them? All the time	c.	Yes No (063) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
For reading or class work		(064) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
For distance vision		(065) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
At other times - Specify _____		(066) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
d. Does (did) he have trouble with his vision even when wearing glasses (or contact lenses)?	d.	(067) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. How old was he when he first wore glasses (or contact lenses)?	e.	(068) --- Years
22. Has . . . ever had to miss school because of trouble seeing or other trouble with his eyes?	22.	(069) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Here are some questions about . . . 's mother:		
23a. How much does she weigh?	23a.	(070) --- Pounds 999 <input type="checkbox"/> Don't know
b. How tall is she?	b.	(071) --- Feet --- Inches 999 <input type="checkbox"/> Don't know
Here are some questions about . . . 's father:		
24a. How much does he weigh?	24a.	(072) --- Pounds 999 <input type="checkbox"/> Don't know
b. How tall is he?	b.	(073) --- Feet --- Inches 999 <input type="checkbox"/> Don't know
25a. Do you use iodized table salt?	25a.	(074) 1 <input type="checkbox"/> Yes } Skip to 26a 2 <input type="checkbox"/> No } 3 <input type="checkbox"/> Don't know - Ask b
b. May I see your box of table salt?	b.	(075) 1 <input type="checkbox"/> Iodized 2 <input type="checkbox"/> Not iodized 3 <input type="checkbox"/> No box
26a. Name of respondent _____		
b. Respondent's relationship to child covered by this questionnaire	b.	(076) 1 <input type="checkbox"/> Mother 2 <input type="checkbox"/> Other
NOTES		

APPENDIX IIE. MEDICAL HISTORY QUESTIONNAIRE, AGES 12-74

<small>FORM 41-10 (MADE IN U.S.A.) REV. 1/71</small> DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY MEDICAL HISTORY QUESTIONNAIRE - AGES 12-74			<small>Form Approved G.P.S. No. 55-R1184</small> ASSURANCE OF CONFIDENTIALITY <small>All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purpose (22 FR 1687).</small>		
a. Name (Last, first, middle)			b. Deck No. 081	c. Sample No.	d. Segment No.
e. Serial No.	f. Column No.	g. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	h. Age	i. Date of Birth Month Day Year	
1a. Do you have an illness or condition which interferes with your eating?		1a. (081) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 2a			
b. What?					
2a. Do you have an illness which has recently cut down your appetite?		2a. (082) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3a			
b. What?					
3a. Do you have trouble chewing steaks, chops, or other firm meats?		3a. (083) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
b. Do you have trouble biting apples or corn-on-the-cob?		b. (084) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
c. Do you have trouble biting or chewing any other food?		c. (085) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
4a. Are there any foods which you avoid eating because they disagree with you?		4a. (086) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 5			
b. What are they?		Yes No			
Milk		(087) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Fats		(088) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Greens		(089) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Seafood		(090) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Other - Specify		(091) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
5. Do you have episodes (or "spells") of pain or discomfort in your abdomen or stomach of at least 3 days per month? (Don't count ones that go with a cold, sore throat, flu or (for women) menstrual periods.)		5. (092) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
6. Do you have difficulty in swallowing at least 3 days per month? (Don't count ones that go with a cold, sore throat or flu.)		6. (093) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
7. Do you have episodes (or "spells") of vomiting of at least 3 days per month? (Don't count ones that go with colds, sore throats, flu, or (for women) menstrual periods.)		7. (094) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
8. Have you ever had yellow jaundice, which made your skin or eyes turn yellow?		8. (095) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
9a. Did a doctor ever tell you that you had protein, albumin, blood or sugar in your urine?		9a. (096) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 10			
b. Which?		Yes No			
Protein		(097) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Albumin		(098) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Blood		(099) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Sugar		(100) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
10. During the past six months have you had parasites or worms in your stools?		10. (021) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know			
11a. Do you have trouble with your bowels which makes you constipated or gives you diarrhea?		11a. (022) 1 <input type="checkbox"/> Yes - constipated 2 <input type="checkbox"/> Yes - diarrhea 3 <input type="checkbox"/> No			
b. How often do you usually have a bowel movement?		b. (023) 1 <input type="checkbox"/> Once a week or less often 2 <input type="checkbox"/> 2 - 3 times a week 3 <input type="checkbox"/> 4 - 6 times a week 4 <input type="checkbox"/> Once a day 5 <input type="checkbox"/> 2 - 3 times a day 6 <input type="checkbox"/> 4 or more times a day			
c. Have your movements ever been white, gray, dark black, or streaked with blood?		c. (024) 1 <input type="checkbox"/> Yes - Ask d 2 <input type="checkbox"/> No - SKIP to 12a			
d. Which?		Yes No			
White		(025) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Gray		(026) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Dark black		(027) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			
Streaked with blood		(028) 1 <input type="checkbox"/> 2 <input type="checkbox"/>			

12a. Have you had an abdominal operation?		12a.		<input type="checkbox"/> 1 Yes - Ask 12b <input type="checkbox"/> 2 No - SKIP to 13a			
b. What for?				Yes No			
Ulcers		<input type="checkbox"/> 031 1 <input type="checkbox"/> 2					
Gallstones		<input type="checkbox"/> 032 1 <input type="checkbox"/> 2					
Hiatus hernia of the diaphragm		<input type="checkbox"/> 033 1 <input type="checkbox"/> 2					
Tumor of the stomach, bowel, or colon		<input type="checkbox"/> 034 1 <input type="checkbox"/> 2					
Tumor or cyst of the womb or ovaries		<input type="checkbox"/> 035 1 <input type="checkbox"/> 2					
Other - Specify		<input type="checkbox"/> 036 1 <input type="checkbox"/> 2					
13a. Has a doctor ever told you that you had any of the following conditions? If "Yes" to any of the following conditions, ask 13b and 13c for those conditions.		13a.		13b. Do you still have it?		13c. How many years ago did you first have it?	
		No		Yes No Don't know			
Arthritis		<input type="checkbox"/> 037 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 038 ---	
Gout		<input type="checkbox"/> 039 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 039 ---	
Asthma		<input type="checkbox"/> 041 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 042 ---	
Chronic bronchitis or emphysema		<input type="checkbox"/> 043 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 043 ---	
Tuberculosis		<input type="checkbox"/> 045 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 044 ---	
Rheumatic fever		<input type="checkbox"/> 047 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 048 ---	
Heart murmur		<input type="checkbox"/> 048 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 049 ---	
Heart failure		<input type="checkbox"/> 051 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 052 ---	
Heart attack		<input type="checkbox"/> 053 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 054 ---	
High blood pressure		<input type="checkbox"/> 055 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 055 ---	
Stroke		<input type="checkbox"/> 057 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 056 ---	
Ulcers (peptic, stomach, duodenal)		<input type="checkbox"/> 059 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 060 ---	
Enteritis (recurrent or chronic)		<input type="checkbox"/> 061 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 062 ---	
Colitis (spastic colon, mucous colitis)		<input type="checkbox"/> 063 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 064 ---	
Gallstones		<input type="checkbox"/> 065 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 065 ---	
Hepatitis		<input type="checkbox"/> 067 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 066 ---	
Chronic cough		<input type="checkbox"/> 069 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 070 ---	
Pleurisy		<input type="checkbox"/> 071 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 071 ---	
Low blood pressure		<input type="checkbox"/> 073 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 074 ---	
Hives		<input type="checkbox"/> 075 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 075 ---	
Hay fever		<input type="checkbox"/> 077 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 076 ---	
Allergies to foods		<input type="checkbox"/> 079 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 080 ---	
Other allergies		<input type="checkbox"/> 081 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 082 ---	
Thyroid disease		<input type="checkbox"/> 083 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 083 ---	
Diabetes		<input type="checkbox"/> 085 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 084 ---	
Polio or paralysis		<input type="checkbox"/> 087 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 085 ---	
Hiatus hernia (of the diaphragm)		<input type="checkbox"/> 089 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 086 ---	
Loss of blood from stomach or bowels		<input type="checkbox"/> 091 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 087 ---	
Kidney disease or kidney stones		<input type="checkbox"/> 093 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 088 ---	
Malignant tumor or growth		<input type="checkbox"/> 095 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 089 ---	
Benign tumor, growth, or cyst (except fat or skin)		<input type="checkbox"/> 097 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 090 ---	
Trouble with blood not clotting properly		<input type="checkbox"/> 099 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 091 ---	
Nervous breakdown		<input type="checkbox"/> 101 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 092 ---	
Fracture of hip		<input type="checkbox"/> 103 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 093 ---	
Fracture of wrist		<input type="checkbox"/> 105 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 094 ---	
Fracture of spine		<input type="checkbox"/> 107 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 095 ---	
14a. Have you ever had anemia, sometimes called "low blood"?		14a.		<input type="checkbox"/> 109 1 Yes - Ask b <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Don't know } SKIP to 15a			
b. How long ago?		b.		<input type="checkbox"/> 110 --- Years <input type="checkbox"/> 2 Don't remember			
c. Did a doctor tell you that you had anemia?		c.		<input type="checkbox"/> 111 1 Yes - Ask d <input type="checkbox"/> 2 No - SKIP to e			
d. What caused it?		d.		Yes No Don't know			
Poor diet		<input type="checkbox"/> 112 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3					
Childbirth		<input type="checkbox"/> 113 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3					
Accidental loss of blood		<input type="checkbox"/> 114 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3					
Illness		<input type="checkbox"/> 115 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3					
Surgery		<input type="checkbox"/> 116 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3					
Other - Specify		<input type="checkbox"/> 117 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3					
e. Were you treated for this condition by a doctor?		e.		<input type="checkbox"/> 118 1 Yes - Ask f <input type="checkbox"/> 2 No - SKIP to 15a			
f. How?		f.		Yes No			
Better diet		<input type="checkbox"/> 119 1 <input type="checkbox"/> 2					
Iron pills		<input type="checkbox"/> 120 1 <input type="checkbox"/> 2					
Iron shots		<input type="checkbox"/> 121 1 <input type="checkbox"/> 2					
Vitamin pills		<input type="checkbox"/> 122 1 <input type="checkbox"/> 2					
Vitamin shots		<input type="checkbox"/> 123 1 <input type="checkbox"/> 2					
Transfusions		<input type="checkbox"/> 124 1 <input type="checkbox"/> 2					
Other - Specify		<input type="checkbox"/> 125 1 <input type="checkbox"/> 2					
g. Are you still being treated for it?		g.		<input type="checkbox"/> 126 1 Yes <input type="checkbox"/> 2 No			

15a. Have you EVER had trouble seeing?	15a.	(127)	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 16a
b. Did you see a doctor about it?	b.	(128)	1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 16a
c. What did he say the trouble was? _____			
16a. Have you ever worn glasses or contact lenses?	16a.	(129)	1 <input type="checkbox"/> Yes, glasses } Ask b 2 <input type="checkbox"/> Yes, contact lenses } 3 <input type="checkbox"/> Yes, contacts and glasses . . . } 4 <input type="checkbox"/> No - SKIP to 17
b. Do you still wear them?	b.	(130)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. When do (did) you wear them?	c.		Yes No
All the time	(131)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
For reading or class work	(132)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
For distance vision	(133)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
At other times - Specify _____	(134)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d. Do (did) you have trouble with your vision even when wearing glasses or contact lenses?	d.	(135)	1 <input type="checkbox"/> Yes, with glasses 2 <input type="checkbox"/> Yes, with contacts 3 <input type="checkbox"/> Yes, with both 4 <input type="checkbox"/> No
e. How old were you when you first wore glasses or contact lenses, whichever one was first in case you have worn both?	e.	(136)	1 <input type="checkbox"/> 0 - 4 years old 2 <input type="checkbox"/> 5 - 9 years old 3 <input type="checkbox"/> 10 - 19 years old 4 <input type="checkbox"/> 20 - 29 years old 5 <input type="checkbox"/> 30 - 39 years old 6 <input type="checkbox"/> 40 - 49 years old 7 <input type="checkbox"/> 50 years old or older
17. Have you ever had to miss work or school because of trouble seeing or other trouble with your eyes?	17.	(137)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
18a. During the past year, have you had at least one drink of beer, wine, or liquor?	18a.	(138)	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 19a
b. How often do you drink?	b.	(139)	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Just about every day 3 <input type="checkbox"/> About 2 or 3 times a week 4 <input type="checkbox"/> About 1 - 4 times a month 5 <input type="checkbox"/> More than 3 but less than 12 times a year 6 <input type="checkbox"/> No more than 2 or 3 times a year - SKIP to 19a
c. Which do you most frequently drink -- beer, wine, or liquor?	c.	(140)	1 <input type="checkbox"/> Beer 2 <input type="checkbox"/> Wine 3 <input type="checkbox"/> Liquor
d. When you drink (beer/wine/liquor) how much do you usually drink over 24 hours? (Enter an amount only for the one marked in 18c.)	d.	(141)	___ Glasses of beer ___ Glasses of wine ___ Drinks of liquor
19a. Do you eat dirt or clay, starch, or any materials which might be considered unusual?	19a.	(142)	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 20
b. Which?			Yes No
Dirt or clay	(143)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Starch	(144)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other - Specify _____	(145)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
20. During the past six months, have you used any medicine, drugs, or pills for any of the following?	20.		Regularly Occasionally No
Sleep problems or insomnia	(146)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Headache	(147)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Other pains	(148)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Upset stomach or indigestion	(149)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Weak heart	(150)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Allergies	(151)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Nerves	(152)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Thyroid trouble	(153)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Lack of pep (except thyroid pills)	(154)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Convulsions	(155)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
High blood pressure	(156)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Bowel trouble	(157)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Skin conditions	(158)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Water loss (fluid pills)	(159)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Weight loss (except fluid pills)	(160)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>
Infection (antibiotic or sulfa pills or shots only)	(161)	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 <input type="checkbox"/>

21a. Are you on a special diet?	21a.	(162) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 22
b. What is it for?	b.	Yes No
To lose weight	(163)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Diabetes	(164)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Kidney failure	(165)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Ulcers	(166)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Allergies	(167)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Heart trouble or high blood pressure	(168)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Pregnancy	(169)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Other - Specify	(170)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
c. What kind of diet is this?	c.	Yes No
Low fat	(171)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Low protein	(172)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Low salt	(173)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Low carbohydrate	(174)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Low calorie	(175)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Other - Specify	(176)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
d. Was this diet ordered by a doctor?	d.	(177) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
22. Do you get much exercise in things you do for recreation (sports, or hiking, or anything like that), or hardly any exercise, or in between?	22.	(178) 1 <input type="checkbox"/> Much exercise 2 <input type="checkbox"/> Moderate exercise 3 <input type="checkbox"/> Little or no exercise
23. In your usual day, aside from recreation, are you physically very active, moderately active, or quite inactive?	23.	(179) 1 <input type="checkbox"/> Very active 2 <input type="checkbox"/> Moderately active 3 <input type="checkbox"/> Quite inactive
24a. Do you use iodized table salt?	24a.	(180) 1 <input type="checkbox"/> Yes } SKIP to 25a 2 <input type="checkbox"/> No } 3 <input type="checkbox"/> Don't know - Ask b
b. May I see your box of table salt?	b.	(181) 1 <input type="checkbox"/> Iodized 2 <input type="checkbox"/> Not iodized 3 <input type="checkbox"/> No box
25a. What is the most that you have ever weighed?	25a.	(182) ___ Pounds
b. How old were you then?	b.	(183) ___ Years old
INTERVIEWER CHECK ITEM		(184) 1 <input type="checkbox"/> Ages 18 and over - Ask 26a 2 <input type="checkbox"/> Under 18 - SKIP to next "INTERVIEWER CHECK ITEM"
26a. What is the least you have weighed since you were 18?	26a.	(185) ___ Pounds
b. How old were you then?	b.	(186) ___ Years old
INTERVIEWER CHECK ITEM		(187) 1 <input type="checkbox"/> Female - Ask 27a 2 <input type="checkbox"/> Male - END OF QUESTIONNAIRE
27a. How old were you when your periods or menstrual cycles started?	27a.	(188) ___ Years - Ask b or Haven't started yet - END OF QUESTIONNAIRE
b. Have they entirely stopped?	b.	(189) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 28a
c. At what age?	c.	(190) ___ Years
28a. Have you taken birth control pills during the past six months?	28a.	(191) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 29a
b. Are you taking them now?	b.	(192) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
29a. Are you or have you ever been pregnant?	29a.	(193) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - END OF QUESTIONNAIRE
b. What is the total number of pregnancies you have had?	b.	(194) ___ Number
c. What is the total number of miscarriages you have had?	c.	(195) ___ Number
d. What is the total number of live births you have had?	d.	(196) ___ Number
e. Are you pregnant now?	e.	(197) 1 <input type="checkbox"/> Yes - Ask f 2 <input type="checkbox"/> No } SKIP to g 3 <input type="checkbox"/> Don't know }
f. Which month of pregnancy are you in?	f.	(198) ___ Month
g. Have you had a pregnancy which ended within the last twelve months?	g.	(199) 1 <input type="checkbox"/> Yes - Ask h 2 <input type="checkbox"/> No - END OF QUESTIONNAIRE
h. How many months ago did that pregnancy end?	h.	(200) 1 <input type="checkbox"/> 10 - 12 months ago 2 <input type="checkbox"/> 7 - 9 months ago 3 <input type="checkbox"/> 4 - 6 months ago 4 <input type="checkbox"/> 0 - 3 months ago
i. Are you breast feeding?	i.	(201) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

APPENDIX IIF. GENERAL MEDICAL HISTORY SUPPLEMENT, AGES 25-74

HS-411-1 (FACE 1) REV. 7/71			Form Approved O.M.B. No. 68-11184		
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY			ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purpose (22 F.R. 1687).		
a. Name (Last, first, middle)		b. Deck No.	c. Sample No.	d. Segment No.	
		091			
e. Serial No.	f. Column No.	g. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	h. Age	i. DATE of birth Month Day Year	
1. Would you say your health in general is excellent, very good, good, fair, or poor?		1.	001	1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor	
2a. Do you have any health problems now that you would like to talk to a doctor about?		2a.	002	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3a	
b. What are the problems?		b.	DATA PREPARATION USE ONLY		
			003	007	011
			004	008	012
			005	009	013
			006	010	014
3a. Have you had a cold, flu or "the virus" during the past month?		3a.	018	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 4a	
b. Do you still have it?		b.	019	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
4a. In the past five years have you had any injury resulting in a broken bone?		4a.	020	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 5	
b. Which bone?		b.	Yes No		
Hip			021	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Wrist			022	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Spine			023	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other (Specify)			024	1 <input type="checkbox"/>	2 <input type="checkbox"/>
5. In the past five years have you had a back injury?		5.	025	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
6a. In the past year have you stayed in a hospital overnight or longer?		6a.	026	1 <input type="checkbox"/> Yes - Ask b and c 2 <input type="checkbox"/> No - SKIP to 7a	
b. For what condition?		b.	DATA PREPARATION USE ONLY		
(1) First			027	---	
(2) Second			028	---	
(3) Third			029	---	
c. How long were you in the hospital?		c.	030		
(1) First condition			-- weeks 00 <input type="checkbox"/> Less than one week		
(2) Second condition			031		
(3) Third condition			-- weeks 00 <input type="checkbox"/> Less than one week		
7a. Have you smoked at least 100 cigarettes during your entire life?		7a.	033	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 8a	
b. Do you smoke cigarettes now?		b.	034	1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to d	
c. On the average, about how many a day do you smoke?		c.	035	-- cigarettes per day (Enter answer and SKIP to e)	
d. How long has it been since you smoked cigarettes fairly regularly?		d.	036	77 <input type="checkbox"/> Under one year - Ask e -- years - Enter number of years and SKIP to f 88 <input type="checkbox"/> Never smoked cigarettes regularly - SKIP to 8a 99 <input type="checkbox"/> Don't know - Ask e	
e. On the average, about how many cigarettes a day were you smoking 12 months ago?		e.	037	-- cigarettes per day 88 <input type="checkbox"/> Did not smoke 99 <input type="checkbox"/> Don't know	
f. During the period when you were smoking the most, about how many cigarettes a day did you usually smoke?		f.	038	-- cigarettes per day 99 <input type="checkbox"/> Don't know	
g. About how old were you when you first started smoking cigarettes fairly regularly?		g.	039	-- years old 88 <input type="checkbox"/> Never smoked regularly 99 <input type="checkbox"/> Don't know	

8a. Have you smoked at least 50 cigars during your entire life?	8a.	<input type="checkbox"/> 040 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 9a								
b. Do you smoke cigars now?	b.	<input type="checkbox"/> 041 1 Yes - Ask c <input type="checkbox"/> 2 No - SKIP to c								
c. About how many cigars a day do you smoke?	c.	<input type="checkbox"/> 042 — cigars per day - SKIP to f f (IF LESS THAN 1 PER DAY) <input type="checkbox"/> 1 3 to 6 per week - SKIP to f <input type="checkbox"/> 2 Less than 3 per week - Ask d								
d. About how long has it been since you smoked 3 or more cigars a week?	d.	<input type="checkbox"/> 043 77 Under 1 year - SKIP to f — years - Enter number of years and SKIP to 9a <input type="checkbox"/> 88 Never smoked 3 or more cigars a week - SKIP to 9a <input type="checkbox"/> 99 Don't know - SKIP to f								
e. About how long has it been since you smoked 3 or more cigars a week?	e.	<input type="checkbox"/> 044 77 Under 1 year - Ask f — years - Enter number of years and SKIP to 9a <input type="checkbox"/> 88 Never smoked 3 or more cigars a week - SKIP to 9a <input type="checkbox"/> 99 Don't know - Ask f								
f. Twelve months ago, about how many cigars a day did you usually smoke?	f.	<input type="checkbox"/> 045 — cigars per day f (IF LESS THAN 1 PER DAY) <input type="checkbox"/> 1 3 to 6 per week <input type="checkbox"/> 2 Less than 3 per week <input type="checkbox"/> 3 Did not smoke cigars								
9a. Have you smoked at least 3 packages of pipe tobacco during your entire life?	9a.	<input type="checkbox"/> 047 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 10a								
b. Do you smoke a pipe now?	b.	<input type="checkbox"/> 048 1 Yes - Ask c <input type="checkbox"/> 2 No - SKIP to e								
c. About how many pipefuls of tobacco a day do you usually smoke?	c.	<input type="checkbox"/> 049 — pipefuls per day - SKIP to f on page 4 f (IF LESS THAN 1 PER DAY) <input type="checkbox"/> 1 3 to 6 per week - SKIP to f on page 4 <input type="checkbox"/> 2 Less than 3 per week - Ask d								
d. About how long has it been since you smoked 3 or more pipefuls a week?	d.	<input type="checkbox"/> 051 77 Under 1 year - SKIP to f on page 4 — years - Enter number of years and SKIP to 10a <input type="checkbox"/> 88 Never smoked 3 or more pipefuls a week - SKIP to 10a <input type="checkbox"/> 99 Don't know - SKIP to f on page 4								
e. About how long has it been since you smoked 3 or more pipefuls a week?	e.	<input type="checkbox"/> 052 77 Under 1 year - Ask f on page 4 — years - Enter number of years and SKIP to 10a <input type="checkbox"/> 88 Never smoked 3 or more pipefuls a week - SKIP to 10a <input type="checkbox"/> 99 Don't know - Ask f on page 4								
f. Twelve months ago, about how many pipefuls a day did you smoke?	f.	<input type="checkbox"/> 053 — pipefuls per day f (IF LESS THAN 1 PER DAY) <input type="checkbox"/> 1 3 to 6 per week <input type="checkbox"/> 2 Less than 3 per week <input type="checkbox"/> 3 Did not smoke a pipe								
10a. Do you presently use any other form of tobacco, such as snuff or chewing tobacco?	10a.	<input type="checkbox"/> 055 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 11a								
b. What?	b.	<table border="0"> <thead> <tr> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 056 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td><input type="checkbox"/> 057 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td><input type="checkbox"/> 058 1</td> <td><input type="checkbox"/> 2</td> </tr> </tbody> </table>	Yes	No	<input type="checkbox"/> 056 1	<input type="checkbox"/> 2	<input type="checkbox"/> 057 1	<input type="checkbox"/> 2	<input type="checkbox"/> 058 1	<input type="checkbox"/> 2
Yes	No									
<input type="checkbox"/> 056 1	<input type="checkbox"/> 2									
<input type="checkbox"/> 057 1	<input type="checkbox"/> 2									
<input type="checkbox"/> 058 1	<input type="checkbox"/> 2									
Snuff										
Chewing tobacco										
Other (Specify)										
HEARING										
11a. At any time over the past few years, have you ever noticed ringing in your ears, or have you been bothered by other funny noises in your ears?	11a.	<input type="checkbox"/> 059 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 12a								
b. How often?	b.	<input type="checkbox"/> 060 1 Every few days <input type="checkbox"/> 2 Less often								
c. Does it bother you?	c.	<input type="checkbox"/> 061 1 Quite a bit <input type="checkbox"/> 2 Just a little <input type="checkbox"/> 3 Not at all								
12a. Have you ever had a running ear or any discharge from your ears (not counting wax in the ears)?	12a.	<input type="checkbox"/> 062 1 Yes - Ask b <input type="checkbox"/> 2 No <input type="checkbox"/> 9 Don't know } SKIP to 13a								
b. How often have you had this?	b.	<input type="checkbox"/> 063 1 Once only <input type="checkbox"/> 3 Three or more times <input type="checkbox"/> 2 Twice <input type="checkbox"/> 4 Don't know								
13a. Have you ever had deafness or trouble hearing with one or both ears?	13a.	<input type="checkbox"/> 064 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 14								
b. Did you ever see a doctor about it?	b.	<input type="checkbox"/> 065 1 Yes <input type="checkbox"/> 2 No								
c. How old were you when you first began having trouble hearing?	c.	<input type="checkbox"/> 066 1 0-4 years old <input type="checkbox"/> 5 30-39 years old <input type="checkbox"/> 2 5-9 years old <input type="checkbox"/> 6 40-49 years old <input type="checkbox"/> 3 10-19 years old <input type="checkbox"/> 7 50 years old or older <input type="checkbox"/> 4 20-29 years old								
d. Since this trouble began, has it gotten worse, gotten better, or stayed about the same?	d.	<input type="checkbox"/> 067 1 Gotten worse <input type="checkbox"/> 3 Stayed about the same <input type="checkbox"/> 2 Gotten better								

13a. What was the cause of your hearing trouble or deafness?		13b.	
		Yes	No
Ear infection	(066)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Born with it	(069)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Loud noise (such as that from machinery, gun fire, blasts or explosions)	(070)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Ear surgery	(071)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Ear injury	(072)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other (Specify)	(073)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Don't know	(074)	3 <input type="checkbox"/>	
f. How would you rate your hearing in your RIGHT ear?	(075)	1 <input type="checkbox"/> Good 2 <input type="checkbox"/> A little decreased 3 <input type="checkbox"/> A lot decreased 4 <input type="checkbox"/> Deaf	
g. How would you rate your hearing in your LEFT ear?	(076)	1 <input type="checkbox"/> Good 2 <input type="checkbox"/> A little decreased 3 <input type="checkbox"/> A lot decreased 4 <input type="checkbox"/> Deaf	
h. Have you ever attended a school or class for those with poor hearing or a school for the deaf?	(077)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
i. Have you ever had any training in lip reading?	(078)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
j. Have you ever had any training in speech or in speech correction because of poor hearing?	(079)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
k. Have you ever had any training in how to use your hearing?	(080)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
l. Have you ever had an operation on your ears?	(081)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
m. Have you ever had your hearing tested?	(082)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to p on page 6	
n. How old were you when your hearing was first tested?	(083)	1 <input type="checkbox"/> 0-9 years old 2 <input type="checkbox"/> 10-19 years old 3 <input type="checkbox"/> 20-29 years old 4 <input type="checkbox"/> 30 years old or older	
o. How often do you now have your hearing tested?	(084)	1 <input type="checkbox"/> Twice a year 2 <input type="checkbox"/> Once a year 3 <input type="checkbox"/> Once every two years 4 <input type="checkbox"/> Less often than once every two years	
p. Have you ever used a hearing aid?	(085)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP TO 14	
q. Which ear?	(086)	1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both	
r. With a hearing aid, is your hearing better?	(087)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
READ - The following series of questions will be about specific medical problems or conditions you might have had in the past, or might even have at the present time. Please answer "Yes" or "No" to each question.			
14. Have you ever had--	14.		
a. Pain or aching in any of your joints either at rest or when moving them, this condition being present for AT LEAST ONE MONTH?	(088)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
b. Pain in your neck or back, this pain having been present for AT LEAST ONE MONTH?	(089)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
c. Pain in or around either hip joint (including the buttock, groin, and side of the upper thigh) or knee (including the back of the knee), this pain having been present for AT LEAST ONE MONTH?	(090)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
d. Swelling of a joint, with pain present in the joint when touched, this condition present for AT LEAST ONE MONTH?	(091)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. Stiffness in the joints and muscles when getting out of bed in the morning, the stiffness lasting for AT LEAST 15 MINUTES?	(092)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. Trouble with recurring persistent cough attacks?	(093)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. A cough first thing in the morning in the winter? (Count a cough with first sneezing or on first going out of doors; exclude clearing of throat or a single cough.)	(094)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
h. A cough first thing in the morning in the summer?	(095)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
i. Any phlegm from your chest first thing in the morning in the winter? (Count phlegm with the first sneeze or on going out of doors; exclude phlegm from the nose. (Count swallowed phlegm.)	(096)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
j. Any phlegm from your chest first thing in the morning in the summer?	(097)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
k. During the past three years, a period of increased cough and phlegm lasting for three weeks or more?	(098)	1 <input type="checkbox"/> Yes - How many times? 2 <input type="checkbox"/> No - SKIP to 14L	
	(099)	1 <input type="checkbox"/> One time 2 <input type="checkbox"/> Two times 3 <input type="checkbox"/> More than two times	

14L. Trouble with shortness of breath, when hurrying on the level or walking up a slight hill?	14L.	(100) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
m. Wheezy or whistling sounds in your chest?	m.	(101) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
n. Trouble with any pain or discomfort in your chest?	n.	(102) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
o. Trouble with any pressure or heaviness sensation in your chest?	o.	(103) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
p. Severe pain across the front of your chest lasting for half an hour or more?	p.	(104) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
q. Pains in either leg when walking?	q.	(105) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
r. Heart failure, or "weak heart", of any degree of severity?	r.	(106) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
s. Infections of the kidneys or bladder?	s.	(107) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
t. Blood in your urine?	t.	(108) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
u. Pain or burning sensation when passing urine?	u.	(109) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
v. Loss of vision or blindness lasting from several minutes to several days?	v.	(110) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
w. Difficulty in speaking or very slurred speech lasting from several minutes to several days?	w.	(111) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
x. Prolonged weakness or paralysis of one or both sides of the body lasting up to several months?	x.	(112) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
y. Loss of sensation or numbness or tingling sensations lasting several minutes to several days?	y.	(113) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
z. A severe head injury leading to unconsciousness lasting for more than five minutes?	z.	(114) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
DIABETES		
15a. Do you have any reason to think that you may have diabetes, sometimes called sugar diabetes or sugar disease?	15a.	(115) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 16a
b. Did a doctor tell you that you had it?	b.	(116) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 16a
c. How long ago did you start having it?	c.	(117) 1 <input type="checkbox"/> Less than one year ago 2 <input type="checkbox"/> 1-4 years ago 3 <input type="checkbox"/> 5 or more years ago
d. Do you take insulin?	d.	(118) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. Do you take any medicine by mouth for diabetes?	e.	(119) 1 <input type="checkbox"/> Yes - Ask f 2 <input type="checkbox"/> No - SKIP to 16a
f. What is the name of the medicine?		
GOITER/THYROID		
16a. Have you ever had a goiter or any other thyroid trouble?	16a.	(120) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 17a
b. Who told you that you had goiter or thyroid trouble?	b.	(121) 1 <input type="checkbox"/> A doctor 3 <input type="checkbox"/> Other 2 <input type="checkbox"/> A nurse
c. Is, or was, your thyroid; Overactive (hyperactive) Underactive (hypoactive)	c.	(122) 1 <input type="checkbox"/> Overactive 3 <input type="checkbox"/> Neither 2 <input type="checkbox"/> Underactive 4 <input type="checkbox"/> Don't know
d. How long ago did you first have this trouble?	d.	(123) 1 <input type="checkbox"/> Less than one year ago 3 <input type="checkbox"/> 5-9 years ago 2 <input type="checkbox"/> 1-4 year ago 4 <input type="checkbox"/> 10 or more years ago
e. Have you been treated by a doctor for goiter or for thyroid trouble?	e.	(124) 1 <input type="checkbox"/> Yes - Ask f 2 <input type="checkbox"/> No - SKIP to 17a
f. How?	f.	Yes No
Medicines	(125)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Surgery	(126)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Radiation	(127)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
Other - Specify →	(128)	1 <input type="checkbox"/> 2 <input type="checkbox"/>
g. Are you currently being treated for this problem?	g.	(129) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. Are you currently taking any pills or medicine to help you lose or gain weight?	h.	(130) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<p>i. When was the last time you saw a doctor about goiter or thyroid trouble?</p>	<p>1. (131) 1 <input type="checkbox"/> Less than one month ago 2 <input type="checkbox"/> 1-3 months ago 3 <input type="checkbox"/> 4-6 months ago 4 <input type="checkbox"/> 7-11 months ago 5 <input type="checkbox"/> 1 or more years ago 9 <input type="checkbox"/> Don't know 6 <input type="checkbox"/> Never</p>
SKIN CONDITIONS	
<p>17a. Have you ever had any of the following skin conditions?</p> <p>Acne or pimples</p> <p>Psoriasis</p> <p>Moles or birthmarks</p> <p>Unusual loss of hair</p> <p>Eczema</p> <p>Warts</p> <p>Hives</p>	<p>17a. Yes No</p> <p>(132) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(133) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(134) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(135) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(136) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(137) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(138) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
<p>b. If "Yes" - Were you treated by a doctor for it?</p> <p>Acne or pimples</p> <p>Psoriasis</p> <p>Moles or birthmarks</p> <p>Unusual loss of hair</p> <p>Eczema</p> <p>Warts</p> <p>Hives</p>	<p>b. Yes No</p> <p>(139) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(140) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(141) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(142) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(143) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(144) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(145) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
TEETH	
<p>18a. Have you lost all your teeth from your upper jaw?</p>	<p>18a. (146) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 19a</p>
<p>b. Do you have a plate for your upper jaw?</p>	<p>b. (147) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to d</p>
<p>c. How long have you had your plate?</p>	<p>c. (148) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years</p> <p style="text-align: right;">} SKIP to 19a</p>
<p>d. Have you ever had a dental plate for your upper jaw?</p>	<p>d. (149) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. How long has it been since you had any teeth to chew with (natural or false) in your upper jaw?</p>	<p>e. (150) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years</p>
<p>19a. Have you lost all your teeth from your lower jaw?</p>	<p>19a. (151) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 20</p>
<p>b. Do you have a plate for your lower jaw?</p>	<p>b. (152) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to d</p>
<p>c. How long have you had your plate?</p>	<p>c. (153) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years</p> <p style="text-align: right;">} SKIP to 20</p>
<p>d. Have you ever had a dental plate for your lower jaw?</p>	<p>d. (154) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>e. How long has it been since you had any teeth to chew with in your lower jaw?</p>	<p>e. (155) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-4 years 3 <input type="checkbox"/> 5-9 years 4 <input type="checkbox"/> 10-19 years 5 <input type="checkbox"/> 20 or more years</p>

<p>• If the respondent doesn't have any full plates, ("No" to questions 18b and 19b) SKIP to the instructions above question 24.</p>		
20. Do you usually wear your plate(s) while eating?	20.	(156) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
21. Do you usually wear your plate(s) when not eating?	21.	(157) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
22. Do you usually use denture powder or cream to help keep your plate(s) in place?	22.	(158) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
23. Do you think you need a new plate or that the one(s) you have need(s) relining?	23.	(159) 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes, one 3 <input type="checkbox"/> Yes, both 4 <input type="checkbox"/> Don't know
<p>• If respondent has no natural teeth, ("Yes" to questions 18a and 19a) questionnaire COMPLETED. • If the respondent has any natural teeth, CONTINUE.</p>		
24. How would you describe the condition of your TEETH?	24.	(160) 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Good 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Poor
25. How would you describe the condition of your GUMS?	25.	(161) 1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Good 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Poor
26. Do you think that your teeth need cleaning now by a dentist or dental hygienist?	26.	(162) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know
27. How many times a day do you usually brush your teeth?	27.	(163) — Times
28. Do you think that you ought to go to a dentist now or very soon for a checkup?	28.	(164) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know
29. Do you now have an appointment to see a dentist?	29.	(165) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
30. Do you think you have any teeth that need filling?	30.	(166) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know
31a. Do you think you have any teeth that need to be pulled?	31a.	(167) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know } SKIP to 32a
b. How many?	b.	(168) 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> All
32a. Have you ever had your teeth cleaned by a dentist or dental hygienist?	32a.	(169) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - END OF INTERVIEW
b. When was the last time they were cleaned?	b.	(170) 1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-2 years ago 3 <input type="checkbox"/> 3-4 years ago 4 <input type="checkbox"/> 5 or more years ago
		(171)
		(172)
NOTES		

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
 PUBLIC HEALTH SERVICE
 HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
 NATIONAL CENTER FOR HEALTH STATISTICS
 HEALTH AND NUTRITION EXAMINATION SURVEY

FORM APPROVED
 O.M.B. NO. 85-R1184

ASSURANCE OF CONFIDENTIALITY - All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

HSM 425-16
 REV. 4-71

DIETARY - 24 HOUR RECALL

NAME: _____

SAMPLE NO. (1-5)	SEGMENT (6-11)	SERIAL (12-13)	COLUMN (14-15)	RESP. CODE (16)	DATE OF BIRTH (17-22) MO. DAY YEAR	*SEX* (23)	WEIGHT-LBS. (24-28)	DATE AND DAY OF WEEK OF RECALL				
								MONTH (29-30)	DATE (31-32)	YEAR (33-34)	DAY (35)	

PUNCH A NEW CARD FOR EACH FOOD ITEM

ING. PER. (36)	FOOD CODE (37-41)	FOODS AND BEVERAGES CONSUMED		WORK AREA FOR COMPUTATIONS (If needed)	SIZE OF EDIBLE PORTION SERVED			TIME OF DAY (37-60)	FOOD SOURCE CODE (61)	LINE CARD NO. (62-63)
		FOOD ITEM	DESCRIPTION		I (42-46)	II (47-51)	III (52-56)			
										01
										02
										03
										04
										05
										06
										07
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										17
										18
										19
										20
										21
										22
										23
										24

RESPONDENT CODE

- 1 - SAMPLE PERSON
- 2 - SPOUSE
- 3 - PARENT
- 4 - GRANDPARENT
- 5 - COMBINATION OF ABOVE
- 6 - OTHER

***SEX* CODE (Use highest applicable code)**

- 1 - MALE
- 2 - FEMALE EXCEPT PREG. OR BREAST FEEDING
- 3 - PREG. 1-4 MOS.
- 4 - PREG. 5-9 MOS.
- 5 - BREAST FEEDING
- 6 - BREAST FEEDING/PREG. 1-4 MOS.
- 7 - BREAST FEEDING/PREG. 5-9 MOS.

INGESTION PERIOD CODE

- 1 - A. M.
- 2 - NOON
- 3 - BETWEEN MEALS
- 4 - P. M.
- 5 - TOTAL DAY

FOOD SOURCE CODE

- 1 - HOME
- 2 - SCHOOL
- 3 - RESTAURANT
- 4 - OTHER

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
HEALTH AND NUTRITION EXAMINATION SURVEY

FORM APPROVED
O.M.B. NO. 69-R1184

ASSURANCE OF CONFIDENTIALITY - All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes. (22 FR 1687).

HSM 425-18
REV. 4/71

NAME _____

DIETARY - FREQUENCY

BEGIN CARD NO. 1

SAMPLE NO. (1-5)	SEGMENT (6-11)	SERIAL (12-13)	COLUMN (14-15)	RESP. CODE (16)	DATE OF BIRTH (17-22)			"SEX" (23)	DATE OF INTERVIEW (24-29)						
					MO.	DAY	YEAR		MO.	DAY	YEAR				
1. MILK (BEVERAGE AND ON CEREALS)				NO. OF TIMES (30-31)	INTERVAL (32)			NO. OF TIMES (63-64)	INTERVAL (65)						
A) WHOLE FRESH MILK					0	D1	W2	7	9		0	D1	W2	7	9
B) SKIM MILK OR BUTTERMILK				(33-34)		0	D1	W2	7	9	9. BUTTER AND MARGARINE				
2. MEAT AND POULTRY All kinds such as beef, pork, lamb, veal, chicken, turkey, etc.				(36-37)		0	D1	W2	7	9	10. DESSERTS AND SWEETS such as: cake, pie, cookies, puddings, ice cream				
3. FISH OR SHELL FISH				(39-40)		0	D1	W2	7	9	11. "CANDY"				
4. EGGS				(42-43)		0	D1	W2	7	9	BEGIN CARD NO. 2 Repeat Columns 1-16 from Card No. 1				
5. CHEESE AND CHEESE DISHES				(45-46)		0	D1	W2	7	9	12. BEVERAGES				
6. DRY BEANS AND PEAS like Pinto beans, red beans, black-eye peas, peanuts and peanut butter				(48-49)		0	D1	W2	7	9	A) COLD DRINKS, SUCH AS SODA, COLA, LEMONADE, KOOL-AID, MADE WITH SUGAR				
7. FRUITS AND VEGETABLES				(51-52)		0	D1	W2	7	9	B) COLD DRINKS, AS ABOVE, ARTIFICIALLY SWEETENED OR "DIET" DRINKS				
A) ALL KINDS - FRESH, CANNED, FROZEN, COOKED, OR RAW, JUICES				(54-55)		0	D1	W2	7	9	C) COFFEE OR TEA				
B) FRUITS AND VEGETABLES RICH IN VITAMIN A (See guidelines)				(57-58)		0	D1	W2	7	9	13. SNACK FOODS (potato chips, corn chips, cheese snacks, etc.)				
C) FRUITS AND VEGETABLES RICH IN VITAMIN C (See guidelines)				(60-61)		0	D1	W2	7	9	INTERVIEWER'S CODE (75-77) COMPLETION CODE (78) CARD NO. 2 (79-80)				
8. BREAD				(62)		0	D1	W2	7	9	NO. OF TIMES CODE INTERVAL CODE "SEX" CODE (Use highest applicable code)				
A) BREAD, ROLLS, BISCUITS, MUFFINS, CORNBREAD											00-NONE OR NEVER 0-NEVER 1-MALE 5-BREAST FEEDING				
											99-UNKNOWN 1-DAILY 2-FEMALE EXCEPT 6-BREAST FEEDING/ PREG. 1-4 MOS.				
											77-LESS THAN ONCE 2-WEEKLY 7-LESS THAN ONCE 7-BREAST FEEDING/ A WEEK PREG. 1-4 MOS.				
											4-PREG. 5-9 MOS. 9-UNKNOWN 8-OTHER				
											RESPONDENT CODE COMPLETION CODE				
											1-SAMPLE PERSON 1-COMPLETED SATISFACTORY				
											2-SPOUSE 2-COMPLETED U "SATISFACTORY (SPECIFY)				
											3-PARENT 3-REFUSAL 4-NOT AVAILABLE 5-INFORMANT INCAPABLE				
											4-GRANDPARENT 5-COMBINATION OF ABOVE 6-OTHER				
											6-OTHER				

APPENDIX IIJ. HEALTH CARE NEEDS QUESTIONNAIRE

HHS-414 (PAGE 1) REV. 5/71		Form Approved O.P.S. No. 68-R1184	
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND STATISTICS ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY		ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).	
HEALTH CARE NEEDS			
a. Name (Last, first, middle) _____			
b. Deck No.	c. Sample No.	d. Segment No.	e. Serial No.
181			
f. Column No. _____			
READ - I need to ask you a number of questions about doctors, dentists, hospitals, and other people who might give you medical care, just how you use them, and what your opinion is on some questions about health care. Your answers will be kept confidential.			
DOCTORS			
1. When was the last time you talked to a doctor about your own health . . .			
		Never	Less than 2 weeks ago
		2 Weeks through 5 months ago	6 through 11 months ago
		1 but less than 2 years ago	2 through 4 years ago
		5 or more years ago	
at a private doctor's office?	(001)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
at a hospital outpatient clinic?	(002)	3 <input type="checkbox"/>	4 <input type="checkbox"/>
at a city clinic?	(003)	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at a clinic at work?	(004)	7 <input type="checkbox"/>	8 <input type="checkbox"/>
at another type clinic?	(005)	9 <input type="checkbox"/>	0 <input type="checkbox"/>
at a hospital emergency room?	(006)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
at home?	(007)	3 <input type="checkbox"/>	4 <input type="checkbox"/>
over the telephone?	(008)	5 <input type="checkbox"/>	6 <input type="checkbox"/>
in another way? - Specify _____	(009)	7 <input type="checkbox"/>	8 <input type="checkbox"/>
2. What was the MAIN reason for your last visit with a doctor? (Check only one.)	2.	(10) 1 <input type="checkbox"/> A sickness or illness - What was the problem? _____ 2 <input type="checkbox"/> An injury-- What was the problem? _____ 3 <input type="checkbox"/> A follow-up visit 4 <input type="checkbox"/> A regular checkup 5 <input type="checkbox"/> An injection 6 <input type="checkbox"/> For a prescription 7 <input type="checkbox"/> Some other reason	
3a. For this last visit, how long was it from the time you decided you should see a doctor until you actually saw him:	3a.	(11) 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 9 <input type="checkbox"/> Don't remember	
b. Did you have an appointment to see him?	b.	(12) 1 <input type="checkbox"/> Yes - Ask c 2 <input type="checkbox"/> No - SKIP to 4	
c. How long was it from the time you made the appointment until you saw him?	c.	(13) 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 9 <input type="checkbox"/> Don't remember	
d. Was this time longer than you would have liked?	d.	(14) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Don't remember	
4. From what place did you leave to go to the doctor?	4.	(15) 1 <input type="checkbox"/> From home 2 <input type="checkbox"/> From work 3 <input type="checkbox"/> From some other place	
5. How did you get from there to the doctor?	5.	(16) 1 <input type="checkbox"/> Walked 2 <input type="checkbox"/> Bus 3 <input type="checkbox"/> Own car 4 <input type="checkbox"/> Someone else's car 5 <input type="checkbox"/> Cab 6 <input type="checkbox"/> Ambulance 7 <input type="checkbox"/> Other means	
6. How long did it take to get there?	6.	(17) 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 15-29 minutes 3 <input type="checkbox"/> 30-59 minutes 4 <input type="checkbox"/> 1 hour or more 9 <input type="checkbox"/> Don't remember	
7a. At this last visit, about how many minutes did you have to wait before being seen by the doctor?	7a.	(18) _____ minutes	
b. Do you think this wait was too long?	b.	(19) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	

8. How well satisfied were you with this visit?	8. (020) 1 <input type="checkbox"/> Satisfied 2 <input type="checkbox"/> Not completely satisfied 3 <input type="checkbox"/> Dissatisfied 4 <input type="checkbox"/> No opinion
9a. During the past 12 months, have you had a health problem which you would have liked to see a doctor about but did not for some reason? b. What was the reason you did not see a doctor?	9a. (021) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 10 b. Yes No Lack of confidence in available doctors (022) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Didn't have time (023) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Would cost too much (024) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Couldn't get an appointment (025) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Would have to travel too far (026) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Didn't have a way to get there (027) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Was afraid of finding out what was wrong (028) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Didn't have anyone to care for children or other family members (029) 1 <input type="checkbox"/> 2 <input type="checkbox"/> Other - Specify (030) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
10a. When did you last have a general checkup or examination, not counting exams made during a visit for an illness?	10. (031) 1 <input type="checkbox"/> Never - SKIP to 13 2 <input type="checkbox"/> Less than 6 months ago 3 <input type="checkbox"/> 6-11 months ago 4 <input type="checkbox"/> 1 but less than 2 years ago 5 <input type="checkbox"/> 2 years ago or more 6 <input type="checkbox"/> Don't remember
11. Where did you get this general examination?	11. (032) 1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Hospital clinic 3 <input type="checkbox"/> Another clinic 4 <input type="checkbox"/> Some other place - Specify _____
12. During this last general examination, were you given -	12. Yes No a cardiogram? (033) 1 <input type="checkbox"/> 2 <input type="checkbox"/> a blood pressure check? (034) 1 <input type="checkbox"/> 2 <input type="checkbox"/> a chest x-ray? (035) 1 <input type="checkbox"/> 2 <input type="checkbox"/> blood tests? (036) 1 <input type="checkbox"/> 2 <input type="checkbox"/> a urinalysis? (037) 1 <input type="checkbox"/> 2 <input type="checkbox"/> vision tests? (038) 1 <input type="checkbox"/> 2 <input type="checkbox"/> hearing tests? (039) 1 <input type="checkbox"/> 2 <input type="checkbox"/> a rectal examination? (040) 1 <input type="checkbox"/> 2 <input type="checkbox"/> an internal examination (FEMALES ONLY)? (041) 1 <input type="checkbox"/> 2 <input type="checkbox"/> e <input type="checkbox"/> Not applicable
13a. When was the last time you received any shots, immunizations or vaccinations to prevent an illness, excluding shots for allergy? b. Why did you get this shot?	13a. (042) 1 <input type="checkbox"/> Never - SKIP to 14 2 <input type="checkbox"/> Less than 6 months ago 3 <input type="checkbox"/> 6-11 months ago 4 <input type="checkbox"/> 1-2 years ago 5 <input type="checkbox"/> 3-5 years ago 6 <input type="checkbox"/> 6-9 years ago 7 <input type="checkbox"/> 10 years ago or more 8 <input type="checkbox"/> Don't remember b. (043) 1 <input type="checkbox"/> Foreign travel 2 <input type="checkbox"/> During military service 3 <input type="checkbox"/> Participation in community or work-sponsored immunization campaign (for example, polio or flu) 4 <input type="checkbox"/> Other - Specify _____
14a. Is there a particular doctor you see regularly or whom you would go to if something were bothering you? b. If you couldn't see this doctor, is there some other particular doctor you would want to see if something were bothering you?	14a. (044) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 15 b. (045) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know
15. Except in an emergency, do you need to have an appointment in order to see a doctor?	15. (046) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
16. When you go to a doctor, do you like the doctor to talk to you about your condition or do you like him just to treat it?	16. (047) 1 <input type="checkbox"/> Talk 2 <input type="checkbox"/> Just treat
17. Do the doctors you usually see talk to you about your condition?	17. (048) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
18. Do you try out home remedies or any that you can get without a prescription before going to your doctor about a problem?	18. (049) 1 <input type="checkbox"/> Yes, often 2 <input type="checkbox"/> Yes, sometimes 3 <input type="checkbox"/> No
NOTES	

DENTIST								
19. Do you have a dentist you usually go to?	19.	(040) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
20. When was the last time you visited or talked with a dentist about yourself.	20.		Less than 6 months ago	6 through 11 months ago	1 but less than 2 years ago	2 through 4 years ago	5 or more years ago	
at a dentist's office?	(051)	Never	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at a hospital dental clinic?	(052)		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at a hospital emergency clinic?	(053)		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
at another clinic (work, school, etc.)	(054)		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
over the telephone?	(055)		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
In another way? - Specify _____	(056)		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
21. What was the MAIN reason for your last visit or talk with a dentist at either his office or at a clinic?	21.	(057) 1 <input type="checkbox"/> Adjustment or repair of dental plate 2 <input type="checkbox"/> To have a dental plate made 3 <input type="checkbox"/> Toothache 4 <input type="checkbox"/> Tooth pulled or other surgery 5 <input type="checkbox"/> Trouble with gums 6 <input type="checkbox"/> Regular checkup visit 7 <input type="checkbox"/> For cleaning teeth 8 <input type="checkbox"/> To have teeth filled 9 <input type="checkbox"/> For a prescription 0 <input type="checkbox"/> Some other reason - Specify _____						
22. For this last visit, how long was it from the time you decided you needed or wanted to see a dentist until you actually saw him?	22.	(058) 1 <input type="checkbox"/> Less than one day 5 <input type="checkbox"/> 1-2 months 2 <input type="checkbox"/> 1-6 days 6 <input type="checkbox"/> 3 months or more 3 <input type="checkbox"/> 1 week but less than 2 weeks 7 <input type="checkbox"/> Don't remember 4 <input type="checkbox"/> 2-3 weeks						
23a. At the time of this last visit or talk with a dentist did you have an appointment?	23a.	(059) 1 <input type="checkbox"/> Yes - Ask 23b 2 <input type="checkbox"/> No - SKIP to 24						
b. How long was it from the time you made the appointment until you saw him?	b.	(060) 1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 week but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 7 <input type="checkbox"/> Don't remember						
c. Was this wait longer than you would have liked it?	c.	(061) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't remember						
24. How did you get to the dentist's office?	24.	(062) 1 <input type="checkbox"/> Walked 2 <input type="checkbox"/> Bus or subway 3 <input type="checkbox"/> Car 4 <input type="checkbox"/> Cab 5 <input type="checkbox"/> Other means - Specify _____						
25. How long did it take to get there?	25.	(063) 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 15-29 minutes 3 <input type="checkbox"/> 30-59 minutes 4 <input type="checkbox"/> 1 hour or more 5 <input type="checkbox"/> Don't remember						
26a. At this last visit with a dentist, about how many minutes did you have to wait before being seen by the dentist?	26a.	(064) _____ minutes						
b. Do you think this wait was too long?	b.	(065) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
27. How well satisfied were you with this visit?	27.	(066) 1 <input type="checkbox"/> Satisfied 2 <input type="checkbox"/> Not completely satisfied 3 <input type="checkbox"/> Dissatisfied 4 <input type="checkbox"/> No opinion						
28. Does your dentist or dental clinic call you or send you a note to remind you when your next regular checkup is due?	28.	(067) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know						
29a. During the past 12 months, have you had a dental problem which you would have liked to see a dentist about but you didn't see the dentist?	29a.	(068) 1 <input type="checkbox"/> Yes - Ask 29b 2 <input type="checkbox"/> No - SKIP to 30						
29b. Why didn't you see him?	29b.	Yes	No					
Didn't have time	(069)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					
Would cost too much	(070)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					
Couldn't get an appointment	(071)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					
Would have to travel too far	(072)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					
Didn't have a way to get there	(073)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					
Didn't have anyone to care for children or other family members	(074)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					
Some other reason	(075)	1 <input type="checkbox"/>	2 <input type="checkbox"/>					

HOSPITAL								
30. When was the last time you stayed in a hospital overnight or longer?	30.	(976)	1 <input type="checkbox"/> Never - SKIP to 36 2 <input type="checkbox"/> Less than 1 month ago 3 <input type="checkbox"/> 1-5 months ago 4 <input type="checkbox"/> 6-11 months ago 5 <input type="checkbox"/> One year ago or more 6 <input type="checkbox"/> Don't remember					
31. Was this stay in the hospital on account of an emergency or was it planned in advance?	31.	(977)	1 <input type="checkbox"/> Planned 2 <input type="checkbox"/> Emergency					
32. What was the MAIN reason you went into the hospital that time?	32.	(978)	1 <input type="checkbox"/> Sickness or illness 2 <input type="checkbox"/> Injury 3 <input type="checkbox"/> Surgery 4 <input type="checkbox"/> Child birth } SKIP to 34 5 <input type="checkbox"/> Checkup } 6 <input type="checkbox"/> Some other reason - Specify and SKIP to 34					
33a. When you went into the hospital for this _____, just what was the problem? _____								
b. How long was it from the time it was decided you needed to go into the hospital until you went in?	b.	(979)	1 <input type="checkbox"/> Less than one day 2 <input type="checkbox"/> 1-6 days 3 <input type="checkbox"/> 1 but less than 2 weeks 4 <input type="checkbox"/> 2-3 weeks 5 <input type="checkbox"/> 1-2 months 6 <input type="checkbox"/> 3 months or more 7 <input type="checkbox"/> Don't remember					
34a. What part of the doctor's bill did you or your family have to pay out of your own pocket for the treatment the doctor gave you while you were in the hospital?	34a.	(980)	1 <input type="checkbox"/> None - SKIP to 35 2 <input type="checkbox"/> Less than half 3 <input type="checkbox"/> More than half, but not all 4 <input type="checkbox"/> All 5 <input type="checkbox"/> Don't know - SKIP to 35					
b. Did you get any of this money back from your health insurance?	b.	(981)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
35a. What part of this hospital bill did you or your family have to pay out of your own pocket?	35a.	(982)	1 <input type="checkbox"/> None - SKIP to 36 2 <input type="checkbox"/> Less than half 3 <input type="checkbox"/> More than half, but not all 4 <input type="checkbox"/> All 5 <input type="checkbox"/> Don't know - SKIP to 36					
b. Did you get any of this money back from your health insurance?	b.	(983)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
36a. When you see a doctor at his office or at a clinic, what part of the cost do you or your family usually have to pay out of your own pocket?	36a.	(984)	1 <input type="checkbox"/> Never been to a doctor - SKIP to 37 2 <input type="checkbox"/> None - SKIP to 37 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> More than half, but not all 5 <input type="checkbox"/> All 6 <input type="checkbox"/> Don't know - SKIP to 37					
b. Do you get any of this money back from your health insurance?	b.	(985)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
37a. Whenever you see a dentist at either his office or at a clinic, what part of the cost do you or your family have to pay out of your own pocket?	37a.	(986)	1 <input type="checkbox"/> Never been to a dentist - SKIP to 38 2 <input type="checkbox"/> None - SKIP to 38 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> More than half, but not all 5 <input type="checkbox"/> All 6 <input type="checkbox"/> Don't know - SKIP to 38					
b. Do you get any of this money back from your health insurance?	b.	(987)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
38a. What part of the cost of drugs and medicines prescribed by your doctor do you pay out of your own pocket?	38a.	(988)	1 <input type="checkbox"/> No drugs or medicines ever prescribed - SKIP to 39 2 <input type="checkbox"/> None - SKIP to 39 3 <input type="checkbox"/> Less than half 4 <input type="checkbox"/> More than half, but not all 5 <input type="checkbox"/> All 6 <input type="checkbox"/> Don't know - SKIP to 39					
b. Do you get any of this money back from your health insurance?	b.	(989)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
39. Do you have insurance or coverage for medical care under	39.			39b. What part of your medical bills does it pay?				
		Yes	No	Less than half	More than half but not all	All	Don't know	
Medicare (for elderly)?	(990)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(996) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Private medical insurance?	(991)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(997) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Insurance through your place of work?	(992)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(998) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Medicaid (for all ages)?	(993)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(101) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Retired military privileges?	(994)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(102) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Veterans medical care?	(995)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(103) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Some other government assistance program? - Specify _____	(996)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(104) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
Some other way?	(997)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(105) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	

APPENDIX IIK. GENERAL WELL-BEING QUESTIONNAIRE

HSB-411-7 (PAGE 1) REV. 8/71		Form Approved O.M.B. No. 68-R1184		
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY GENERAL WELL-BEING		ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).		
a. Name (Last, first, middle)	b. Deck No. 171	c. Sample No. -- -- -- --	d. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	e. Age --
READ - This section of the examination contains questions about how you feel and how things have been going with you. For each question, mark (X) the answer which best applies to you.				
1. How have you been feeling in general? (DURING THE PAST MONTH)	1.	(00)	1 <input type="checkbox"/> In excellent spirits 2 <input type="checkbox"/> In very good spirits 3 <input type="checkbox"/> In good spirits mostly 4 <input type="checkbox"/> I have been up and down in spirits a lot 5 <input type="checkbox"/> In low spirits mostly 6 <input type="checkbox"/> In very low spirits	
2. Have you been bothered by nervousness or your "nerves"? (DURING THE PAST MONTH)	2.	(00)	1 <input type="checkbox"/> Extremely so -- to the point where I could not work or take care of things 2 <input type="checkbox"/> Very much so 3 <input type="checkbox"/> Quite a bit 4 <input type="checkbox"/> Some -- enough to bother me 5 <input type="checkbox"/> A little 6 <input type="checkbox"/> Not at all	
3. Have you been in firm control of your behavior, thoughts, emotions OR feelings? (DURING THE PAST MONTH)	3.	(00)	1 <input type="checkbox"/> Yes, definitely so 2 <input type="checkbox"/> Yes, for the most part 3 <input type="checkbox"/> Generally so 4 <input type="checkbox"/> Not too well 5 <input type="checkbox"/> No, and I am somewhat disturbed 6 <input type="checkbox"/> No, and I am very disturbed	
4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (DURING THE PAST MONTH)	4.	(00)	1 <input type="checkbox"/> Extremely so -- to the point that I have just about given up 2 <input type="checkbox"/> Very much so 3 <input type="checkbox"/> Quite a bit 4 <input type="checkbox"/> Some -- enough to bother me 5 <input type="checkbox"/> A little bit 6 <input type="checkbox"/> Not at all	
5. Have you been under or felt you were under any strain, stress, or pressure? (DURING THE PAST MONTH)	5.	(00)	1 <input type="checkbox"/> Yes -- almost more than I could bear or stand 2 <input type="checkbox"/> Yes -- quite a bit of pressure 3 <input type="checkbox"/> Yes -- some - more than usual 4 <input type="checkbox"/> Yes -- some - but about usual 5 <input type="checkbox"/> Yes - a little 6 <input type="checkbox"/> Not at all	
6. How happy, satisfied, or pleased have you been with your personal life? (DURING THE PAST MONTH)	6.	(00)	1 <input type="checkbox"/> Extremely happy -- could not have been more satisfied or pleased 2 <input type="checkbox"/> Very happy 3 <input type="checkbox"/> Fairly happy 4 <input type="checkbox"/> Satisfied -- pleased 5 <input type="checkbox"/> Somewhat dissatisfied 6 <input type="checkbox"/> Very dissatisfied	
7. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or all your memory? (DURING THE PAST MONTH)	7.	(00)	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Only a little 3 <input type="checkbox"/> Some -- but not enough to be concerned or worried about 4 <input type="checkbox"/> Some and I have been a little concerned 5 <input type="checkbox"/> Some and I am quite concerned 6 <input type="checkbox"/> Yes, very much so and I am very concerned	
8. Have you been anxious, worried, or upset? (DURING THE PAST MONTH)	8.	(00)	1 <input type="checkbox"/> Extremely so -- to the point of being sick or almost sick 2 <input type="checkbox"/> Very much so 3 <input type="checkbox"/> Quite a bit 4 <input type="checkbox"/> Some -- enough to bother me 5 <input type="checkbox"/> A little bit 6 <input type="checkbox"/> Not at all	
9. Have you been waking up fresh and rested? (DURING THE PAST MONTH)	9.	(00)	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> Most every day 3 <input type="checkbox"/> Fairly often 4 <input type="checkbox"/> Less than half the time 5 <input type="checkbox"/> Rarely 6 <input type="checkbox"/> None of the time	
10. Have you been bothered by any illness, bodily disorder, pains, or fears about your health? (DURING THE PAST MONTH)	10.	(01)	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time	
11. Has your daily life been full of things that were interesting to you? (DURING THE PAST MONTH)	11.	(01)	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time	
12. Have you felt down-hearted and blue? (DURING THE PAST MONTH)	12.	(01)	1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time	

13. Have you been feeling emotionally stable and sure of yourself? (DURING THE PAST MONTH)	13.	(Q13) 1 <input type="checkbox"/> All of the time. 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time
14. Have you felt tired, worn out, used-up, or exhausted? (DURING THE PAST MONTH)	14.	(Q14) 1 <input type="checkbox"/> All of the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> A good bit of the time 4 <input type="checkbox"/> Some of the time 5 <input type="checkbox"/> A little of the time 6 <input type="checkbox"/> None of the time
15. How concerned or worried about your HEALTH have you been? (DURING THE PAST MONTH)	15.	(Q15) For each of the four scales below, note that the words at each end of the 0 to 10 scale describe opposite feelings. Circle any number along the bar which seems closest to how you have generally felt DURING THE PAST MONTH. 0 1 2 3 4 5 6 7 8 9 10 Not concerned at all Very concerned
16. How RELAXED or TENSE have you been? (DURING THE PAST MONTH)	16.	(Q16) 0 1 2 3 4 5 6 7 8 9 10 Very relaxed Very tense
17. How much ENERGY, PEP, VITALITY have you felt? (DURING THE PAST MONTH)	17.	(Q17) 0 1 2 3 4 5 6 7 8 9 10 No energy AT ALL, listless Very ENERGETIC, dynamic
18. How DEPRESSED or CHEERFUL have you been? (DURING THE PAST MONTH)	18.	(Q18) 0 1 2 3 4 5 6 7 8 9 10 Very depressed Very cheerful
19. Have you had severe enough personal, emotional, behavior, or mental problems that you felt you needed help DURING THE PAST YEAR?	19.	(Q19) 1 <input type="checkbox"/> Yes, and I did seek professional help 2 <input type="checkbox"/> Yes, but I did not seek professional help 3 <input type="checkbox"/> I have had (or have now) severe personal problems, but have not felt I needed professional help 4 <input type="checkbox"/> I have had very few personal problems of any serious concern 5 <input type="checkbox"/> I have not been bothered at all by personal problems during the past year
20. Have you ever felt that you were going to have, or were close to having, a nervous breakdown?	20.	(Q20) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No
21. Have you ever had a nervous breakdown?	21.	(Q21) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No
22. Have you ever been a patient (or outpatient) at a mental hospital, a mental health ward of a hospital, or a mental health clinic, for any personal, emotional, behavior, or mental problem.	22.	(Q22) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No
23. Have you ever seen a psychiatrist, psychologist, or psychoanalyst about any personal, emotional, behavior, or mental problem concerning yourself?	23.	(Q23) 1 <input type="checkbox"/> Yes -- during the past year 2 <input type="checkbox"/> Yes -- more than a year ago 3 <input type="checkbox"/> No
24. Have you talked with or had any connection with any of the following about some personal, emotional, behavior, mental problem, worries, or "nerves" CONCERNING YOURSELF DURING THE PAST YEAR?	24.	
a. Regular medical doctor (except for definite physical conditions or routine check-ups)	a.	(Q24) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
b. Brain or nerve specialist	b.	(Q25) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Nurse (except for routine medical conditions)	c.	(Q26) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
d. Lawyer (except for routine legal services)	d.	(Q27) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. Police (except for simple traffic violations)	e.	(Q28) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
f. Clergymen, minister, priest, rabbi, etc.	f.	(Q29) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
g. Marriage Counselor	g.	(Q30) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. Social Worker	h.	(Q31) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
i. Other formal assistance:	i.	(Q32) 1 <input type="checkbox"/> Yes - What kind? _____ 2 <input type="checkbox"/> No
25. Do you discuss your problems with any members of your family or friends?	25.	(Q33) 1 <input type="checkbox"/> Yes - and it helps a lot 2 <input type="checkbox"/> Yes - and it helps some 3 <input type="checkbox"/> Yes - but it does not help at all 4 <input type="checkbox"/> No - I do not have anyone I can talk with about my problems 5 <input type="checkbox"/> No - no one cares to hear about my problems 6 <input type="checkbox"/> No - I do not care to talk about my problems with anyone 7 <input type="checkbox"/> No - I do not have any problems
26. Filled out by:	26.	(Q34) 1 <input type="checkbox"/> Examinee 2 <input type="checkbox"/> Interviewer 3 <input type="checkbox"/> Mixed

1r. Have you ever had a ruptured disc in either your back or neck?	1r. 035 1 <input type="checkbox"/> Yes - Ask s 2 <input type="checkbox"/> No - SKIP to v
s. At what age?	s. 036 -- years
t. Were you in traction?	t. 037 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
u. Was surgery necessary?	u. 038 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
v. Have you ever stayed overnight in a hospital for back or neck pain?	v. 039 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
2a. Have you had pain in or around either hip joint (including the buttock, groin, and side of the upper thigh) on most days for at least one month?	2a. 040 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3a
b. Has this pain in the hip area been present on any one occasion for at least six weeks?	b. 041 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. Where did you first notice it?	c. 042 1 <input type="checkbox"/> Left hip 2 <input type="checkbox"/> Right hip 3 <input type="checkbox"/> Both hips
d. In the hip area, where is the pain usually most intense?	d.
Right buttock	043 Yes No 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Left buttock	044 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Both buttocks	045 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Right groin	046 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Left groin	047 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Both groins	048 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Side of right thigh	049 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Side of left thigh	050 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Sides of both upper thighs	051 1 <input type="checkbox"/> 2 <input type="checkbox"/>
Other - Specify _____	052 1 <input type="checkbox"/> 2 <input type="checkbox"/>
e. From the hip, has the pain tended to spread to -	e.
the inside of your leg?	053 Yes No 1 <input type="checkbox"/> 2 <input type="checkbox"/>
the front of your leg?	054 1 <input type="checkbox"/> 2 <input type="checkbox"/>
the outside of your leg?	055 1 <input type="checkbox"/> 2 <input type="checkbox"/>
the back of your leg?	056 1 <input type="checkbox"/> 2 <input type="checkbox"/>
f. Have you had pain in or around the hip when either coughing or sneezing?	f. 057 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
g. When this hip pain is present, does it hurt at rest as well as when moving?	g. 058 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. How old were you when you first experienced this recurring pain in the hip?	h. 059 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20 - 29 years old 3 <input type="checkbox"/> 30 - 39 years old 4 <input type="checkbox"/> 40 - 49 years old 5 <input type="checkbox"/> 50 - 59 years old 6 <input type="checkbox"/> 60 years old or older
i. When was the last time you had the pain?	i. 060 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1 - 2 years ago 4 <input type="checkbox"/> 3 - 5 years ago 5 <input type="checkbox"/> 6 years ago or more
j. What is the longest episode of hip pain you have ever had?	j. 061 1 <input type="checkbox"/> Less than one month 2 <input type="checkbox"/> One but less than 2 months 3 <input type="checkbox"/> 2 - 3 months 4 <input type="checkbox"/> 4 - 5 months 5 <input type="checkbox"/> 6 months or more 9 <input type="checkbox"/> Don't remember
k. Have you ever had a fractured hip?	k. 062 1 <input type="checkbox"/> Yes - Ask l 2 <input type="checkbox"/> No - SKIP to p
l. Which hip was broken?	l. 063 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
m. How old were you when it happened?	m. 064 -- Years
n. Was the hip in traction?	n. 065 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
o. Was there surgery?	o. 066 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
p. Have you ever had a dislocated hip?	p. 067 1 <input type="checkbox"/> Yes - Ask q 2 <input type="checkbox"/> No - SKIP to 3a
q. Which hip was dislocated?	q. 068 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
r. How old were you when it happened?	r. 069 -- Years
s. Was the hip in traction?	s. 070 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
t. Was there surgery?	t. 071 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
3a. Have you had pain in or around the knee (including the back of the knee) on most days for at least one month?	3a. 072 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 4a
b. Has this pain in the knee area been present on any one occasion for at least six weeks?	b. 073 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

3c. In which knee did you first have it?	3c.	(074) 1 <input type="checkbox"/> Left knee 2 <input type="checkbox"/> Right knee 3 <input type="checkbox"/> Both knees 4 <input type="checkbox"/> Don't remember
d. How old were you when you first experienced recurring pain in the knee?	d.	(075) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20-29 years old 3 <input type="checkbox"/> 30-39 years old 4 <input type="checkbox"/> 40-49 years old 5 <input type="checkbox"/> 50-59 years old 6 <input type="checkbox"/> 60 years old or older
e. When this knee pain is present, where is it most intense?	e.	Yes No (076) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (077) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (078) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (079) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (080) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (081) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
f. When this knee pain is present, does it hurt at rest as well as when moving?	f.	(082) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
g. When this knee pain is present, is there also swelling of the knee joint?	g.	(083) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. When this pain is present, have you every had "locking" of the knee?	h.	(084) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
i. Has either knee ever "given way" under you?	i.	(085) 1 <input type="checkbox"/> Yes - Ask j 2 <input type="checkbox"/> No - SKIP to k
j. Which knee?	j.	(086) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
k. When was the last time you had this knee pain?	k.	(087) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1-2 years ago 4 <input type="checkbox"/> 3-5 years ago 5 <input type="checkbox"/> 6 years ago or more
l. What was the longest episode of knee pain you have ever had?	l.	(088) 1 <input type="checkbox"/> Less than one month 2 <input type="checkbox"/> One but less than 2 months 3 <input type="checkbox"/> 2-3 months 4 <input type="checkbox"/> 4-5 months 5 <input type="checkbox"/> 6 months or more 6 <input type="checkbox"/> Don't remember
m. Have you ever had a fractured knee?	m.	(089) 1 <input type="checkbox"/> Yes - Ask n 2 <input type="checkbox"/> No - SKIP to o
n. Which knee?	n.	(090) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
o. Have you ever had a severe twisting of either knee with resultant sprain or swelling lasting more than two weeks?	o.	(091) 1 <input type="checkbox"/> Yes - Ask p 2 <input type="checkbox"/> No - SKIP to q
p. Which knee?	p.	(092) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
q. Have you ever had any other knee injury?	q.	(093) 1 <input type="checkbox"/> Yes - Ask r 2 <input type="checkbox"/> No - SKIP to 4a
r. Which knee?	r.	(094) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
4a. Have you ever had hip, knee, or back disease treated by an operation?	4a.	(095) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 5a
b. Which joint?	b.	(096) 1 <input type="checkbox"/> Hip 4 <input type="checkbox"/> Hip and knee 2 <input type="checkbox"/> Knee 5 <input type="checkbox"/> Back and knee 3 <input type="checkbox"/> Back 6 <input type="checkbox"/> Hip and back 7 <input type="checkbox"/> ALL
IF HIP: (1) Which hip?	(1)	(097) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
IF KNEE: (2) Which knee?	(2)	(098) 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both
c. What was the operation or procedure? Specify _____		
5a. Have you had pain or aching in any joint other than the hip, back, or knee on most days for at least six weeks?	5a.	(099) 1 <input type="checkbox"/> Yes - Ask b and c 2 <input type="checkbox"/> No - SKIP to 6a
b. Which joints were painful?	b. & c.	Yes No (100) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (101) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (102) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (103) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (104) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (105) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (106) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (107) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (108) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (109) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (110) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
		3c. If "Yes," - Which? Right Left Both (101) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (102) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (103) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (104) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (105) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (106) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (107) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (108) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (109) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (110) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
6a. Have you ever had any swelling of joints with pain present when the joint was touched on most days for at least one month?	6a.	(112) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 7a
b. Has this swelling been present on any one occasion for at least six weeks?	b.	(113) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<p>6c. Which joints are usually involved whenever you have this swelling and tenderness on touching?</p> <p>Fingers.....</p> <p>Wrists.....</p> <p>Elbows.....</p> <p>Shoulders.....</p> <p>Hips.....</p> <p>Knees.....</p> <p>Ankles.....</p> <p>Feet.....</p>	<p>6c. & d.</p> <p>Yes No</p> <p>(114) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(116) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(118) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(120) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(122) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(124) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(126) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(128) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>	<p>6d. If "Yes," - Which?</p> <p>Right Left Both</p> <p>(115) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(117) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(119) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(121) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(123) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(125) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(127) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(129) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p>
<p>6e. How old were you when you first experienced this swelling of the joints?</p>	<p>(130) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20 - 29 years old 3 <input type="checkbox"/> 30 - 39 years old 4 <input type="checkbox"/> 40 - 49 years old 5 <input type="checkbox"/> 50 - 59 years old 6 <input type="checkbox"/> 60 years old or older</p>	
<p>f. When was the last time you had this?</p>	<p>(131) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1 - 2 years ago 4 <input type="checkbox"/> 3 - 5 years ago 5 <input type="checkbox"/> 6 years ago or more</p>	
<p>7a. Have you had stiffness in your joints and muscles when first getting out of bed in the morning on most mornings for at least one month?</p>	<p>(132) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 8a</p>	
<p>b. Has this morning stiffness been present on any one occasion for at least six weeks?</p>	<p>(133) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	
<p>c. Which joints are usually involved whenever you have this morning stiffness?</p> <p>Fingers.....</p> <p>Wrists.....</p> <p>Elbows.....</p> <p>Shoulders.....</p> <p>Hips.....</p> <p>Knees.....</p> <p>Ankles.....</p> <p>Feet.....</p> <p>Back.....</p>	<p>c. & d.</p> <p>Yes No</p> <p>(134) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(136) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(138) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(140) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(142) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(144) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(146) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(148) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(150) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>	<p>7d. If "Yes," - Which?</p> <p>Right Left Both</p> <p>(135) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(137) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(139) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(141) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(143) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(145) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(147) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(149) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p>
<p>e. How long after getting up and moving around does the morning stiffness last?</p>	<p>(152) 1 <input type="checkbox"/> Less than 15 minutes 2 <input type="checkbox"/> 15 minutes to one half hour 3 <input type="checkbox"/> More than one half hour but less than all day 4 <input type="checkbox"/> All day</p>	
<p>f. How old were you when you first experienced this morning stiffness of joints?</p>	<p>(153) 1 <input type="checkbox"/> Less than 20 years old 2 <input type="checkbox"/> 20 - 29 years old 3 <input type="checkbox"/> 30 - 39 years old 4 <input type="checkbox"/> 40 - 49 years old 5 <input type="checkbox"/> 50 - 59 years old 6 <input type="checkbox"/> 60 years old or older</p>	
<p>g. When was the last time you had this?</p>	<p>(154) 1 <input type="checkbox"/> Now 2 <input type="checkbox"/> Less than 1 year ago but not now 3 <input type="checkbox"/> 1 - 3 years ago 4 <input type="checkbox"/> 4 - 9 years ago 5 <input type="checkbox"/> 10 years ago or more</p>	
<p>8a. Have you ever had pain, swelling, or stiffness in a joint as the result of an accident or injury?</p>	<p>(155) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 9</p>	
<p>b. Was this the cause of the pain, swelling, or stiffness mentioned previously, do you think?</p>	<p>(156) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know</p>	
<p>c. Is this the cause of any pain, swelling, or stiffness which might still be present, do you think?</p>	<p>(157) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know</p>	
<p>9. Have you ever been treated by any of the following people for your joint troubles?</p> <p>General practitioner.....</p> <p>Internist.....</p> <p>Rheumatologist.....</p> <p>Orthopedist.....</p> <p>Chiropractor.....</p> <p>Osteopath.....</p> <p>Foot doctor (chiropractist or podiatrist).....</p> <p>Physical therapist.....</p> <p>Occupational therapist.....</p> <p>Other - Specify.....</p> <p>Never been treated.....</p>	<p>9.</p> <p>Yes No</p> <p>(158) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(159) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(160) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(161) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(162) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(163) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(164) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(165) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(166) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(167) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(168) 3 <input type="checkbox"/> SKIP to 11a</p>	

<p>10a. Are you currently being treated by a doctor for the troubles you have just described?</p>	<p>10a. (169) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 11a</p>																																																																																				
<p>b. What type of doctor is he?</p>	<p>b. (170) 1 <input type="checkbox"/> General practitioner 2 <input type="checkbox"/> Internist 3 <input type="checkbox"/> Rheumatologist 4 <input type="checkbox"/> Orthopedist 5 <input type="checkbox"/> Chiropractor 6 <input type="checkbox"/> Osteopath 7 <input type="checkbox"/> Other specialist 8 <input type="checkbox"/> Other - Specify _____</p>																																																																																				
<p>c. What did he say the problem was?</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">DATA PREPARATION USE ONLY</p> <p>(171) 1 <input type="checkbox"/> (174) 1 <input type="checkbox"/> (172) 1 <input type="checkbox"/> (175) 1 <input type="checkbox"/> (173) 1 <input type="checkbox"/> (176) 1 <input type="checkbox"/></p>																																																																																				
<p>d. When was the last time you saw him?</p>	<p>d. (177) 1 <input type="checkbox"/> Less than 1 month ago 2 <input type="checkbox"/> 1 - 3 months ago 3 <input type="checkbox"/> 4 - 6 months ago 4 <input type="checkbox"/> 7 - 11 months ago 5 <input type="checkbox"/> 1 year ago or more 6 <input type="checkbox"/> Don't know</p>																																																																																				
<p>e. Who originally referred you to this doctor?</p>	<p>e. (178) 1 <input type="checkbox"/> No one 2 <input type="checkbox"/> He's the regular doctor 3 <input type="checkbox"/> Another doctor 4 <input type="checkbox"/> Family 5 <input type="checkbox"/> Clinic 6 <input type="checkbox"/> Health nurse 7 <input type="checkbox"/> Friend 8 <input type="checkbox"/> Other - Specify _____</p>																																																																																				
<p>f. Where do you usually see him?</p>	<p>f. (179) 1 <input type="checkbox"/> His office 2 <input type="checkbox"/> At a clinic 3 <input type="checkbox"/> At home 4 <input type="checkbox"/> Other</p>																																																																																				
<p>g. How long will it be until your next visit to him?</p>	<p>g. (180) 1 <input type="checkbox"/> Less than 1 month 2 <input type="checkbox"/> 1 - 2 months 3 <input type="checkbox"/> 3 - 6 months 4 <input type="checkbox"/> 7 - 11 months 5 <input type="checkbox"/> 1 year or more 6 <input type="checkbox"/> Don't know</p>																																																																																				
<p>11a. Have you ever used any of the following kinds of treatment for your joint troubles?</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Splints or casts</td> <td>(181) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(182) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Braces</td> <td>(183) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(184) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Diothermy or paraffin</td> <td>(185) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(186) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Hot packs or heating pads</td> <td>(187) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(188) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Cold packs or ice</td> <td>(189) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(190) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Rest</td> <td>(191) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(192) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Traction</td> <td>(193) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(194) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Exercises or physical therapy</td> <td>(195) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(196) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Aspirin</td> <td>(197) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(198) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Cane</td> <td>(199) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(200) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Crutch</td> <td>(201) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(202) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Stiff mattress</td> <td>(203) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(204) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Bed board</td> <td>(205) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>(206) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>		Yes	No		Yes	No	Splints or casts	(181) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(182) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Braces	(183) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(184) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Diothermy or paraffin	(185) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(186) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Hot packs or heating pads	(187) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(188) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Cold packs or ice	(189) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(190) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Rest	(191) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(192) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Traction	(193) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(194) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Exercises or physical therapy	(195) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(196) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Aspirin	(197) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(198) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Cane	(199) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(200) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Crutch	(201) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(202) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Stiff mattress	(203) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(204) 1 <input type="checkbox"/>	2 <input type="checkbox"/>		Bed board	(205) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(206) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	
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<p>c. If "Yes" to 11a or 11b - Do you use it regularly?</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Splints or casts</td> <td>(207) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Braces</td> <td>(208) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Diothermy or paraffin</td> <td>(209) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Hot packs or heating pads</td> <td>(210) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Cold packs or ice</td> <td>(211) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Rest</td> <td>(212) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Traction</td> <td>(213) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Exercises or physical therapy</td> <td>(214) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Aspirin</td> <td>(215) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Cane</td> <td>(216) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Crutch</td> <td>(217) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Stiff mattress</td> <td>(218) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>Bed board</td> <td>(219) 1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Splints or casts	(207) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Braces	(208) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Diothermy or paraffin	(209) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Hot packs or heating pads	(210) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Cold packs or ice	(211) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Rest	(212) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Traction	(213) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Exercises or physical therapy	(214) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Aspirin	(215) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Cane	(216) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Crutch	(217) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Stiff mattress	(218) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	Bed board	(219) 1 <input type="checkbox"/>	2 <input type="checkbox"/>																																										
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<p>12a. Have you ever had injections into any of your joints?</p>	<p>12a. (220) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 13a</p>																																																																																				
<p>b. Did they do you any good?</p>	<p>b. (221) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																																																																				

<p>13a. Have you ever taken any of the following medications for your joints?</p> <p>Any cortisone-like medicine by mouth</p> <p>Butorzolidin</p> <p>Darvon or Tylenol</p> <p>Indocin</p>	<p>13a. Yes No Don't know</p> <p>(222) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(223) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(224) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p> <p>(225) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/></p>
<p>b. If "Yes" - Did it do any good?</p> <p>Any cortisone-like medicine by mouth</p> <p>Butorzolidin</p> <p>Darvon or Tylenol</p> <p>Indocin</p>	<p>b. Yes No</p> <p>(226) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(227) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(228) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(229) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
<p>14. Can you do the following things without the help of someone else or the help of some special device?</p> <p>Go up or down stairs</p> <p>Get into or out of a car</p> <p>Use washing facilities</p> <p>Dress yourself</p> <p>Feed yourself</p> <p>Get into or out of bed</p>	<p>14. Yes No</p> <p>(230) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(231) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(232) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(233) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(234) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p> <p>(235) 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
<p>15. At the present time, does your joint condition restrict your physical activity very little, quite a bit, or a whole lot?</p>	<p>15. (236) 1 <input type="checkbox"/> Very little 2 <input type="checkbox"/> Quite a bit 3 <input type="checkbox"/> A whole lot</p>
<p>16. Have you ever had to stay in bed at home for long periods of time because of your joints?</p>	<p>16. (237) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>17. Have you ever stayed overnight in a hospital because of joint problems?</p>	<p>17. (238) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>18. With respect to your joint trouble, would you say your condition is mild, moderate, or severe?</p>	<p>18. (239) 1 <input type="checkbox"/> Mild 2 <input type="checkbox"/> Moderate 3 <input type="checkbox"/> Severe</p>
<p>19. What was your job status one month before you first developed your joint condition?</p>	<p>19. (240) 1 <input type="checkbox"/> Retired because of age 2 <input type="checkbox"/> Retired because of disability 3 <input type="checkbox"/> Unemployed 4 <input type="checkbox"/> Working full-time 5 <input type="checkbox"/> Working part-time 6 <input type="checkbox"/> Housewife with full duties 7 <input type="checkbox"/> Housewife with partial or no duties 8 <input type="checkbox"/> Other - Specify</p>
<p>20a. As a result of your joint condition, has there been a change in your job status?</p>	<p>20a. (241) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 21</p>
<p>b. What is it now?</p>	<p>b. (242) 1 <input type="checkbox"/> Retired because of disability 2 <input type="checkbox"/> Unemployed 3 <input type="checkbox"/> Changed to easier job 4 <input type="checkbox"/> Working 5 <input type="checkbox"/> Housewife with partial duties 6 <input type="checkbox"/> Housewife with no duties 7 <input type="checkbox"/> Other - Specify</p>
<p>21. How many work days do you estimate that you lost during the past 12 months as a result of your joint condition?</p>	<p>21. (243) 1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1 - 4 days 3 <input type="checkbox"/> 5 - 9 days 4 <input type="checkbox"/> 10 - 14 days 5 <input type="checkbox"/> 15 - 19 days 6 <input type="checkbox"/> 20 - 29 days 7 <input type="checkbox"/> 30 days or more</p>

APPENDIX IIM. SUPPLEMENT B

<p>HSM-411-3 (Page 1) REV. 5/71</p> <p style="text-align: center;">DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY</p> <p style="text-align: center;">SUPPLEMENT B - RESPIRATORY</p>	<p style="text-align: right;">Form Approved D.M.B. No. 68-R1184</p> <p>ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential and will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).</p>	
a. Name (Last, first, middle)	b. Deck No. 131	c. Sample No. _____
<p>READ - Earlier you mentioned having had either persistent cough, phlegm, wheezing, shortness of breath, asthma, or hay fever. Here are some additional questions about this trouble.</p>		
<p>PERSISTENT COUGHING</p>		
1a. Was your problem that of persistent coughing? Ta.	(001) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 2a	
b. How long have you had this condition? b.	(002) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-3 years 3 <input type="checkbox"/> 4-9 years 4 <input type="checkbox"/> 10 years or more	
c. Have you been bothered by this within the past year? c.	(003) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
d. When you have this trouble, do you also have chest pains? d.	(004) 1 <input type="checkbox"/> Yes - Ask e 2 <input type="checkbox"/> No - SKIP to f	
e. Where? e.	Yes No (005) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (006) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (007) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (008) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (009) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
f. Do you bring up phlegm with the cough? f.	(010) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. Do you cough persistently like this on most days for as much as THREE months each year? g.	(011) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
h. Do any medicines you take help relieve the cough? h.	(012) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
i. What time of year do these coughing attacks seem at their worst? i.	(013) 1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference	
2a. Have you had trouble with coughing spells when you first get up in the early morning? (Count a cough with first awake or on first going out of doors; exclude clearing of throat or a single cough.) 2a.	(014) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3a	
b. How long have you had this particular condition? b.	(015) 1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-3 years 3 <input type="checkbox"/> 4-9 years 4 <input type="checkbox"/> 10 years or more 5 <input type="checkbox"/> Don't know	
c. Do you have chest pains when you have morning coughing spells? c.	(016) 1 <input type="checkbox"/> Yes - Ask d 2 <input type="checkbox"/> No - SKIP to e	
d. Where? d.	Yes No (017) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (018) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (019) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (020) 1 <input type="checkbox"/> 2 <input type="checkbox"/> (021) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
e. What time of year are these morning coughing spells at their worst? e.	(022) 1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference	
f. Do you have a morning cough like this on most days for as much as THREE months each year? f.	(023) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. Do you usually have a persistent cough at other times during the day or at night in the winter? (IGNORE AN OCCASIONAL COUGH.) g.	(024) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
h. Do you usually have a persistent cough at other times during the day or at night in the summer? (IGNORE AN OCCASIONAL COUGH.) h.	(025) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
<p>PHLEGM</p>		
3a. Do you usually bring up any phlegm from your chest first thing in the morning? (Count phlegm with the first smoke or on going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) 3a.	(026) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 4a	
b. How long have you had this condition? b.	(027) 1 <input type="checkbox"/> Less than 1 year 4 <input type="checkbox"/> 10 years or more 2 <input type="checkbox"/> 1-3 years 5 <input type="checkbox"/> Don't know 3 <input type="checkbox"/> 4-9 years	

c. What color is the phlegm?			Yes	No	
Green		028	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Yellow		029	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Clear		030	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Blood-streaked		031	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
d. Do you also bring up any phlegm from your chest at other times during the day or at night, in the winter? (At least two times or more)		d.	032	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. Do you also bring up any phlegm from your chest during the day, or at night, in the summer? (At least two times or more)		e.	033	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. What time of year do you seem to bring up the most phlegm from your chest?		f.	034	1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference	
g. If you have brought up phlegm, do you bring it up on most days for as much as THREE months each year?		g.	035	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
SHORTNESS OF BREATH					
4a. Have you had shortness of breath either when hurrying on the level or walking up a slight hill?		4a.	036	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 5a	
b. Have you had this problem most days for as much as THREE months each year?		b.	037	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
c. Do you get short of breath when walking with other people at an ordinary pace on the level?		c.	038	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
d. Do you have to stop for breath when walking at your own pace on the level?		d.	039	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. Do you have to stop for breath after walking about 100 yards or after a few minutes on the level?		e.	040	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. How long ago did you first have this trouble with shortness of breath?		f.	041	1 <input type="checkbox"/> Less than 1 year ago 2 <input type="checkbox"/> 1-3 years ago 3 <input type="checkbox"/> 4-9 years ago 4 <input type="checkbox"/> 10 years ago or more 5 <input type="checkbox"/> Don't know	
g. Have you gotten chest pains along with the shortness of breath?		g.	042	1 <input type="checkbox"/> Yes - Ask h 2 <input type="checkbox"/> No - SKIP to i	
h. Where?		h.		Yes	No
Upper chest		043	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Upper back		044	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Lower back		045	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Along the lower ribs		046	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
On the sides		047	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
i. Do you develop wheezing as well as shortness of breath?		i.	048	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
j. Have you ever felt like you were going to pass out from the shortness of breath?		j.	049	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
WHEEZING					
5a. Has your chest ever sounded wheezy or whistling?		5a.	050	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 6a	
b. How long have you had this condition?		b.	051	1 <input type="checkbox"/> Less than 1 year 2 <input type="checkbox"/> 1-3 years 3 <input type="checkbox"/> 4-9 years 4 <input type="checkbox"/> 10 years or more	
c. Do you get this wheezing or whistling with colds?		c.	052	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
d. Do you get this occasionally apart from colds?		d.	053	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. Does this usually occur daily?		e.	054	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
f. What time of year does it seem worst?		f.	055	1 <input type="checkbox"/> Winter 2 <input type="checkbox"/> Summer 3 <input type="checkbox"/> No difference	
g. Is this wheeziness present on most days for as much as THREE months each year?		g.	056	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
h. Do you take any medicines for wheezing?		h.	057	1 <input type="checkbox"/> Yes - Ask i 2 <input type="checkbox"/> No - SKIP to 6a	
i. Do they help relieve the wheezing?		i.	058	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> A small amount 3 <input type="checkbox"/> A great deal	
ASTHMA					
6a. Have you had, or do you now have asthma?		6a.	059	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 7a	
b. What is it related to or due to?		b.		Yes	No
Dust		060	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Foods		061	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Animal contacts		062	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Drugs		063	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Pollens		064	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Molds		065	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Other - Specify		066	1 <input type="checkbox"/>	2 <input type="checkbox"/>	
Don't know		067	9 <input type="checkbox"/>		

6c. How long have you had this condition?	6c.	<input type="checkbox"/> 1 Less than 1 year - SKIP to e <input type="checkbox"/> 2 1-3 years - SKIP to e <input type="checkbox"/> 3 4-9 years ago - SKIP to e <input type="checkbox"/> 4 10 years or more - Go to d																														
d. Since you were a child?	d.	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No																														
e. Do you have asthma symptoms on most days for as much as THREE months each year?	e.	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No																														
f. What time of year is it worst?	f.	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Spring</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Summer</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Fall</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Winter</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> </tbody> </table>		Yes	No	Spring	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Summer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Fall	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Winter	<input type="checkbox"/> 1	<input type="checkbox"/> 2															
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Fall	<input type="checkbox"/> 1	<input type="checkbox"/> 2																														
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g. Do you take any medicines for it?	g.	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No																														
HAYFEVER																																
7a. Have you had, or do you now have, hayfever?	7a.	<input type="checkbox"/> 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 8a																														
b. What is it related to or due to?	b.	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Dust</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Foods</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Animal contacts</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Drugs</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Pollens</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Molds</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Air conditioners</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Other - Specify _____</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/> 3</td> <td></td> </tr> </tbody> </table>		Yes	No	Dust	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Foods	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Animal contacts	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Pollens	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Molds	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Air conditioners	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Other - Specify _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Don't know	<input type="checkbox"/> 3	
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c. How long have you had this condition?	c.	<input type="checkbox"/> 1 Less than 1 year - SKIP to e <input type="checkbox"/> 2 1-3 years - SKIP to e <input type="checkbox"/> 3 4-9 years - SKIP to e <input type="checkbox"/> 4 10 years or more - Ask d																														
d. Since you were a child?	d.	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No																														
7e. Do you have hayfever symptoms on most days for as much as THREE months each year?	7e.	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No																														
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g. Do you take any medicines for it?	g.	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No																														
MEDICAL CARE																																
9a. Have you ever been tested for TB (tuberculosis)?	9a.	<input type="checkbox"/> 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 9a																														
b. How were you tested?	b.	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>A skin test</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Chest x-ray</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Sputum examination</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/> 3</td> <td></td> </tr> </tbody> </table>		Yes	No	A skin test	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Chest x-ray	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Sputum examination	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Don't know	<input type="checkbox"/> 3																
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Don't know	<input type="checkbox"/> 3																															
c. How often are you tested?	c.	<input type="checkbox"/> 1 Once every year <input type="checkbox"/> 2 Once every two years <input type="checkbox"/> 3 Once every 3-5 years <input type="checkbox"/> 4 Less often than once every 5 years																														
d. How long ago were you last tested?	d.	<input type="checkbox"/> 1 Less than 1 year ago <input type="checkbox"/> 2 1-2 years ago <input type="checkbox"/> 3 3-5 years ago <input type="checkbox"/> 4 6-9 years ago <input type="checkbox"/> 5 10 years ago or more <input type="checkbox"/> 6 Don't know																														
9a. Have you seen a doctor or anyone else about the chest or lung conditions you mentioned previously?	9a.	<input type="checkbox"/> 1 Yes - Ask b <input type="checkbox"/> 2 No - SKIP to 10																														
b. What is the name of the doctor you see?																																
c. What type of doctor is he?	c.	<input type="checkbox"/> 1 General Practitioner <input type="checkbox"/> 2 Internist <input type="checkbox"/> 3 Osteopath <input type="checkbox"/> 4 Surgeon <input type="checkbox"/> 5 Lung Specialist <input type="checkbox"/> 6 Allergist <input type="checkbox"/> 7 Other - Specify _____																														
d. Who initially referred you to this doctor?	d.	<input type="checkbox"/> 1 No one <input type="checkbox"/> 2 He's the regular doctor <input type="checkbox"/> 3 Another physician <input type="checkbox"/> 4 Health nurse <input type="checkbox"/> 5 Clinic <input type="checkbox"/> 6 Family <input type="checkbox"/> 7 Other - Specify _____																														

<p>9a. How long after you first developed the problem did you see him?</p>	<p>104 1 <input type="checkbox"/> 1-6 days 2 <input type="checkbox"/> 1-7 weeks 3 <input type="checkbox"/> 2-6 months 4 <input type="checkbox"/> 7-11 months 5 <input type="checkbox"/> One year or more 6 <input type="checkbox"/> Don't know</p>
<p>1. What did he say the condition or conditions affecting your chest were?</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>DATA PREPARATION USE ONLY</p> <p>105 1 <input type="checkbox"/> 110 1 <input type="checkbox"/> 115 1 <input type="checkbox"/> 106 1 <input type="checkbox"/> 111 1 <input type="checkbox"/> 107 1 <input type="checkbox"/> 112 1 <input type="checkbox"/> 108 1 <input type="checkbox"/> 113 1 <input type="checkbox"/> 109 1 <input type="checkbox"/> 114 1 <input type="checkbox"/></p>
<p>9. When you see the doctor about your chest condition, how often do you receive a chest x-ray?</p>	<p>116 1 <input type="checkbox"/> At every visit 2 <input type="checkbox"/> At every other visit 3 <input type="checkbox"/> Less often than every other visit</p>
<p>h. Does he prescribe the medicine for the condition?</p>	<p>117 1 <input type="checkbox"/> Yes - Ask I 2 <input type="checkbox"/> No - SKIP to J</p>
<p>1. How is the medicine taken?</p> <p>Swallowed</p> <p>Breathed</p> <p>Injected</p> <p>Other - Specify _____</p>	<p>Yes No</p> <p>118 1 <input type="checkbox"/> 2 <input type="checkbox"/> 119 1 <input type="checkbox"/> 2 <input type="checkbox"/> 120 1 <input type="checkbox"/> 2 <input type="checkbox"/> 121 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
<p>j. Has he told you to do any of these other things for it?</p> <p>Breathing exercises</p> <p>Use a breathing machine</p> <p>Stop smoking</p> <p>Decrease smoking</p> <p>Regular checkup</p> <p>Lots of rest</p> <p>Decrease activity</p> <p>Other - Specify _____</p>	<p>Yes No</p> <p>122 1 <input type="checkbox"/> 2 <input type="checkbox"/> 123 1 <input type="checkbox"/> 2 <input type="checkbox"/> 124 1 <input type="checkbox"/> 2 <input type="checkbox"/> 125 1 <input type="checkbox"/> 2 <input type="checkbox"/> 126 1 <input type="checkbox"/> 2 <input type="checkbox"/> 127 1 <input type="checkbox"/> 2 <input type="checkbox"/> 128 1 <input type="checkbox"/> 2 <input type="checkbox"/> 129 1 <input type="checkbox"/> 2 <input type="checkbox"/></p>
<p>k. When was the last time you saw him?</p>	<p>130 1 <input type="checkbox"/> Less than 1 month ago 2 <input type="checkbox"/> 1-3 months ago 3 <input type="checkbox"/> 4-6 months ago 4 <input type="checkbox"/> 7-11 months ago 5 <input type="checkbox"/> 1 year ago or more 6 <input type="checkbox"/> Don't know</p>
<p>l. Where do you usually see him?</p>	<p>131 1 <input type="checkbox"/> At his office 2 <input type="checkbox"/> At a clinic 3 <input type="checkbox"/> At home 4 <input type="checkbox"/> Other - Specify _____</p>
<p>m. How long will it be until your next appointment?</p>	<p>132 1 <input type="checkbox"/> Less than 1 month 2 <input type="checkbox"/> 1-3 months 3 <input type="checkbox"/> 4-6 months 4 <input type="checkbox"/> 7-11 months 5 <input type="checkbox"/> 1 year or more 6 <input type="checkbox"/> Don't know</p>
<p>10. Within the past 12 months, has your chest condition gotten worse, gotten better, or stayed about the same?</p>	<p>133 1 <input type="checkbox"/> Gotten worse 2 <input type="checkbox"/> Gotten better 3 <input type="checkbox"/> Stayed about the same</p>
<p>11. Have you ever been disabled because of any chest condition?</p>	<p>134 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>12. Have you ever stayed overnight in a hospital because of a chest condition?</p>	<p>135 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>13. What was your job status one month before you first had a problem with a chest or lung condition?</p>	<p>136 1 <input type="checkbox"/> Retired because of age 2 <input type="checkbox"/> Retired because of disability 3 <input type="checkbox"/> Unemployed 4 <input type="checkbox"/> Working full-time 5 <input type="checkbox"/> Working part-time 6 <input type="checkbox"/> Housewife with full duties 7 <input type="checkbox"/> Housewife with partial or no duties 8 <input type="checkbox"/> Other - Specify _____</p>
<p>14a. As a result of your chest or lung condition, has there been a change in your job status?</p>	<p>137 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 15</p>
<p>b. What is it now?</p>	<p>138 1 <input type="checkbox"/> Retired because of disability 2 <input type="checkbox"/> Unemployed 3 <input type="checkbox"/> Working only part-time 4 <input type="checkbox"/> Changed to easier job 5 <input type="checkbox"/> Housewife with partial duties 6 <input type="checkbox"/> Housewife with no duties 7 <input type="checkbox"/> Other - Specify _____</p>
<p>15. How many work days would you estimate you have lost during the past 12 months because of your chest or lung condition, excluding colds or flu?</p>	<p>139 1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1-4 days 3 <input type="checkbox"/> 5-9 days 4 <input type="checkbox"/> 10-14 days 5 <input type="checkbox"/> 15-19 days 6 <input type="checkbox"/> 20-29 days 7 <input type="checkbox"/> 30 days or more</p>

APPENDIX IIN. SUPPLEMENT C

HSE-411-4 PAGE 11 REV. 5-71		Form Approved D.M.B. No. 68-R1184	
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY SUPPLEMENT C - CARDIOVASCULAR		ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of this survey, and will not be disclosed or released to others for any other purposes (32 F.R. 1687).	
a. Name (Last, first, middle)		b. Deck No. 141	c. Sample No. _____
READ - Earlier you mentioned having a history of either chest pain, chest discomfort or heaviness, leg pain while walking, or heart failure. Here are some additional questions about it.			
1a. Was the problem that of chest pain, chest discomfort, pressure, or heaviness?		1a. (001) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 2a	
b. How would you best describe this pain or discomfort?		Yes No	
Heaviness		(002) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Burning sensation		(003) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Tightness		(004) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Stabbing pain		(005) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Pressure		(006) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Sharp pain		(007) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Shooting pains		(008) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
c. Have you had it more than THREE times?		c. (009) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
d. Have you been bothered by this within the past 12 months?		d. (010) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. How old were you when you first had it?		e. (011) 1 <input type="checkbox"/> 10 - 19 years old 4 <input type="checkbox"/> 40 - 49 years old 2 <input type="checkbox"/> 20 - 29 years old 5 <input type="checkbox"/> 50 - 59 years old 3 <input type="checkbox"/> 30 - 39 years old 6 <input type="checkbox"/> 60 years old or older	
f. Do you get it if you walk at an ordinary pace on level ground?		f. (012) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
g. Do you get it if you walk uphill or hurry?		g. (013) 1 <input type="checkbox"/> Yes - Ask h 2 <input type="checkbox"/> No - SKIP to k	
1b. What do you do if you get it while walking?		Yes No	
Stop		(014) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Slow down		(015) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Continue at same pace		(016) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Take medicine		(017) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
i. If you do stop or slow down, is it relieved or not?		i. (018) 1 <input type="checkbox"/> Relieved - Ask j 2 <input type="checkbox"/> Not relieved - SKIP to k	
j. How soon?		j. (019) 1 <input type="checkbox"/> Less than 10 minutes 2 <input type="checkbox"/> 10 minutes or more	
k. When you get pain or discomfort, where is it located?		Yes No	
Upper middle chest		(020) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Lower middle chest		(021) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Left side of chest		(022) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Left arm		(023) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Right side of chest		(024) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Other - Specify		(025) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
l. Do any of these things tend to bring it on?		Yes No	
Excitement or emotion		(026) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Steeping over		(027) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Eating a heavy meal		(028) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Coughing spells		(029) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Cold wind		(030) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
Exercise		(031) 1 <input type="checkbox"/> 2 <input type="checkbox"/>	
2a. Have you ever had severe pain across the front of your chest lasting for half an hour or more?		2a. (032) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 3a	
b. How many of these attacks have you had?		b. (033) 1 <input type="checkbox"/> One 3 <input type="checkbox"/> 4 or more 2 <input type="checkbox"/> 2 - 3	
c. What was the date of your last attack?		c. (034) Month Year	
d. What was the duration of the pain during your last attack?		d. (035) 1 <input type="checkbox"/> 30 - 59 minutes 5 <input type="checkbox"/> 12 - 23 hours 2 <input type="checkbox"/> 1 - 2 hours 6 <input type="checkbox"/> 24 - 47 hours 3 <input type="checkbox"/> 3 - 5 hours 7 <input type="checkbox"/> 2 days or more 4 <input type="checkbox"/> 6 - 11 hours	
e. Did you see a doctor about this last attack?		e. (036) 1 <input type="checkbox"/> Yes - Ask f 2 <input type="checkbox"/> No - SKIP to 3a	
f. What did he say it was?		DATA PREPARATION USE ONLY	
_____		(037) 1 <input type="checkbox"/> (041) 1 <input type="checkbox"/>	
_____		(038) 1 <input type="checkbox"/> (042) 1 <input type="checkbox"/>	
_____		(039) 1 <input type="checkbox"/> (043) 1 <input type="checkbox"/>	
_____		(040) 1 <input type="checkbox"/> (044) 1 <input type="checkbox"/>	

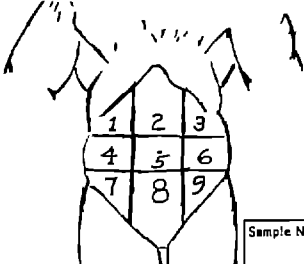
3a. Do you get pain or discomfort in either leg while walking?	3a. (045) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 4a
b. Do you also get this pain in your legs while standing still?	b. (046) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
c. In what parts of your leg do you feel this pain?	c. (047) 1 <input type="checkbox"/> Lower part (calf) 2 <input type="checkbox"/> Upper part (thigh) 3 <input type="checkbox"/> Both lower and upper parts
d. Do you get the pain in your legs while quiet or while sitting?	d. (048) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
e. Do you get it when you walk up a hill in a hurry?	e. (049) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
f. Do you get it when you walk at an ordinary pace on level ground?	f. (050) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
g. Does the pain in your legs come on after you have taken a few steps?	g. (051) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. Does the pain disappear while you are still walking?	h. (053) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
i. What do you do when you get it while you are walking?	i. (053) Yes No 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Stop	(054) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Slow down	(055) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Continue at same pace	(056) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Take medicine	
j. If you stop, is it relieved or not?	j. (057) 1 <input type="checkbox"/> Relieved - Ask k 2 <input type="checkbox"/> Not relieved - SKIP to l
k. How soon after stopping?	k. (058) 1 <input type="checkbox"/> Less than 10 minutes 2 <input type="checkbox"/> 10 minutes or more
l. Is the pain more likely to occur when you are hurrying than when you are walking at a slower, more even pace?	l. (059) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
4a. Have you ever seen a doctor about chest pains, chest discomfort, pains in the legs while walking, or heart failure?	4a. (060) 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 5
b. What is the name of the doctor?	
c. What type of doctor is he?	c. (061) 1 <input type="checkbox"/> General practitioner 3 <input type="checkbox"/> Other - Specify 2 <input type="checkbox"/> Osteopath 3 <input type="checkbox"/> Heart specialist 4 <input type="checkbox"/> Other specialist 5 <input type="checkbox"/> Don't know
d. Who initially referred you to this doctor?	d. Yes No (062) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
No one	(063) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
He's the regular doctor	(064) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Another doctor	(065) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Family	(066) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Clinic	(067) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Health nurse	(068) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Other - Specify _____	
e. How long after this trouble first started did you first visit your doctor about it?	e. (069) 1 <input type="checkbox"/> Less than 1 day 5 <input type="checkbox"/> 1 - 5 months 2 <input type="checkbox"/> 1 - 2 days 6 <input type="checkbox"/> 6 - 11 months 3 <input type="checkbox"/> 3 - 6 days 7 <input type="checkbox"/> 1 year or more 4 <input type="checkbox"/> 1 - 3 weeks 8 <input type="checkbox"/> Don't remember
f. At that time, what did he say the problem was?	
g. Did you have a cardiogram at the first visit?	g. (070) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
h. Did you have one at a later visit?	h. (071) 1 <input type="checkbox"/> Yes - Ask i 2 <input type="checkbox"/> No - SKIP to 4j
i. How long was it from the time of the first visit?	i. (072) 1 <input type="checkbox"/> 1 - 2 days 5 <input type="checkbox"/> 6 - 11 months 2 <input type="checkbox"/> 3 - 6 days 6 <input type="checkbox"/> 1 year or more 3 <input type="checkbox"/> 1 - 3 weeks 7 <input type="checkbox"/> Don't know 4 <input type="checkbox"/> 1 - 5 months
j. Did you have a chest X-ray at the first visit?	j. (073) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
k. Did you have one at a later visit?	k. (074) 1 <input type="checkbox"/> Yes - Ask l 2 <input type="checkbox"/> No - SKIP to m
l. How long was it from the time of the first visit?	l. (075) 1 <input type="checkbox"/> 1 - 2 days 5 <input type="checkbox"/> 6 - 11 months 2 <input type="checkbox"/> 3 - 6 days 6 <input type="checkbox"/> 1 year or more 3 <input type="checkbox"/> 1 - 3 weeks 7 <input type="checkbox"/> Don't know 4 <input type="checkbox"/> 1 - 5 months
m. Have you had any other tests for this condition? (such as blood or urine)	m. (076) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
n. Did the doctor prescribe medicines to take for your condition?	n. (077) 1 <input type="checkbox"/> Yes - Ask o 2 <input type="checkbox"/> No - SKIP to p
o. How do you take the medicine?	o. Yes No (078) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Swallowed	(079) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Under the tongue	(080) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Injected	(081) 1 <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/>
Other - Specify _____	

4p. Has he told you to do any of these other things? 4p.			
Make regular visits	(082)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Have regular cardiograms	(083)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Decrease activity	(084)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Increase activity	(085)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Rest	(086)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Do exercises	(087)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Stop smoking	(088)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other - Specify _____	(089)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
q. When was the last time you saw him? q.	(090)	1 <input type="checkbox"/> Less than 1 month ago 2 <input type="checkbox"/> 1 - 3 months ago 3 <input type="checkbox"/> 4 - 6 months ago 4 <input type="checkbox"/> 7 - 11 months ago 5 <input type="checkbox"/> 1 year ago or more 6 <input type="checkbox"/> Don't remember	
r. Where do you usually see him? r.	(091)	1 <input type="checkbox"/> At his office 2 <input type="checkbox"/> At a clinic 3 <input type="checkbox"/> At home 4 <input type="checkbox"/> Other - Specify _____	
s. How long will it be until your next visit? s.	(092)	1 <input type="checkbox"/> Less than 1 month 2 <input type="checkbox"/> 1 - 3 months 3 <input type="checkbox"/> 4 - 6 months 4 <input type="checkbox"/> 7 - 11 months 5 <input type="checkbox"/> 1 year or more 6 <input type="checkbox"/> Don't know	
t. Would you say that the treatments you have had have done you any good? t.	(093)	1 <input type="checkbox"/> No, not at all 2 <input type="checkbox"/> Yes, partly 3 <input type="checkbox"/> Yes, quite a bit	
5. Within the past 12 months, would you say that your condition has gotten worse, gotten better, or stayed about the same? 5.	(094)	1 <input type="checkbox"/> Gotten worse 2 <input type="checkbox"/> Gotten better 3 <input type="checkbox"/> Stayed about the same	
6. Have you ever been disabled because of chest pain, leg pain, or heart failure? 6.	(095)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
7. Have you ever stayed overnight in a hospital because of chest pain, leg pain, or heart failure? 7.	(096)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
8. What was your job status one month before you first developed chest pain, leg pain, or heart failure? 8.	(097)	1 <input type="checkbox"/> Retired because of age 2 <input type="checkbox"/> Retired because of disability 3 <input type="checkbox"/> Unemployed 4 <input type="checkbox"/> Working full-time 5 <input type="checkbox"/> Working part-time 6 <input type="checkbox"/> Housewife with full duties 7 <input type="checkbox"/> Housewife with partial or no duties 8 <input type="checkbox"/> Other - Specify _____	
9a. As a result of your condition, has there been a change in your job status? 9a.	(098)	1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - SKIP to 10	
b. What is it now? b.	(099)	1 <input type="checkbox"/> Retired because of disability 2 <input type="checkbox"/> Unemployed 3 <input type="checkbox"/> Working only part-time 4 <input type="checkbox"/> Changed to easier job 5 <input type="checkbox"/> Housewife with partial duties 6 <input type="checkbox"/> Housewife with no duties 7 <input type="checkbox"/> Other - Specify _____	
10. How many work days would you estimate you have lost during the past 12 months because of your heart condition? 10.	(100)	1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1 - 4 days 3 <input type="checkbox"/> 5 - 9 days 4 <input type="checkbox"/> 10 - 14 days 5 <input type="checkbox"/> 15 - 19 days 6 <input type="checkbox"/> 20 - 29 days 7 <input type="checkbox"/> 30 days or more	

APPENDIX IIO. EXAMINATION FORMS (ALL EXAMINEES)

HSM-425-1B (PAGE 1) REV. 8/71 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY <p align="center">CONTROL RECORD¹</p>					Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).				
a. Name (Last, first, middle)				b. Deck No. 211		c. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female			
d. Date of birth Month Day Year		e. Age		f. Examination date Month Day Year		g. Temperature			
				(001)		(002)			
PROCEDURE	TIME		NOT DONE	STAFF	Procedure or part of overall procedure not done (Enter reason for non-completion)				
	IN	OUT							
1. Casual specimen	(003)	(004)	x <input type="checkbox"/>						
2. Body measurements	(005)	(006)	x <input type="checkbox"/>						
3. Physician's examination	(007)	(008)	x <input type="checkbox"/>						
4. Venipuncture	(009)	(010)	x <input type="checkbox"/>						
5. Dental examination	(011)	(012)	x <input type="checkbox"/>						
6. Dermatology examination	(013)	(014)	x <input type="checkbox"/>						
7. Ophthalmology I	(015)	(016)	x <input type="checkbox"/>						
8. Ophthalmology II	(017)	(018)	x <input type="checkbox"/>						
9. Nutrition questionnaire	(019)	(020)	x <input type="checkbox"/>						
		(021) 1 <input type="checkbox"/> In home 2 <input type="checkbox"/> Not in home							
10. Hand and wrist X-ray (Ages 1-17)	(022)	(023)	x <input type="checkbox"/>						
OFFICE USE ONLY	Time in		Time out		Sample Number				
(041) N <input type="checkbox"/>									
(071) N <input type="checkbox"/>									
(081) N <input type="checkbox"/>									

¹This control record is used for those examinees receiving only the nutrition component. The form reproduced on page 64 is used for examinees receiving the detailed component.

HS-125-3 (PAGE 1) <small>REV. 9-74</small> DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY GENERAL MEDICAL EXAMINATION - AGES 1-74		Form Approved O.M.B. No. 68-R1184 ASSURANCE OF CONFIDENTIALITY <small>All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).</small>		
a. Name (Last, first, middle)	b. Deck No. 231	c. Pulse (001)	d. Blood pressure (over 6 years) (002) SYSTOLIC (003) DIASTOLIC	
1. HEAD, EYES, EARS, NOSE, AND THROAT: <small>If findings, mark applicable box and continue with a. If no findings, SKIP to 2a.</small> Yes a. Dry, staring hair (009) 1 <input type="checkbox"/> b. Dyspigmented hair (006) 1 <input type="checkbox"/> c. Easily pluckable hair (007) 1 <input type="checkbox"/> d. Abnormal texture or loss of curl (008) 1 <input type="checkbox"/> e. Circumcneal injection (009) 1 <input type="checkbox"/> f. Conjunctival injection (010) 1 <input type="checkbox"/> g. Angular blepharitis (011) 1 <input type="checkbox"/> h. Xerosis (012) 1 <input type="checkbox"/> i. Bitot's spots (013) 1 <input type="checkbox"/> j. Keratomalacia (014) 1 <input type="checkbox"/> k. Xerophthalmia (015) 1 <input type="checkbox"/> l. Angular lesions of lips (016) 1 <input type="checkbox"/> m. Angular scars of lips (017) 1 <input type="checkbox"/> n. Cheilosis (018) 1 <input type="checkbox"/> o. Filiform papillary atrophy of tongue (019) 1 <input type="checkbox"/> p. Fungiform papillary hypertrophy of tongue (020) 1 <input type="checkbox"/> q. Geographic tongue (021) 1 <input type="checkbox"/> r. Fissures of tongue (022) 1 <input type="checkbox"/> s. Serrations or swelling of tongue (023) 1 <input type="checkbox"/> t. Scarlet beefy tongue (024) 1 <input type="checkbox"/> u. Magenta tongue (025) 1 <input type="checkbox"/> v. Naso-labial seborrhea (026) 1 <input type="checkbox"/> w. Visible enlarged parotids (027) 1 <input type="checkbox"/> x. Bossing of skull (028) 1 <input type="checkbox"/> y. Other - Specify _____ (029) 1 <input type="checkbox"/>	(009) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings Yes (009) 1 <input type="checkbox"/> (006) 1 <input type="checkbox"/> (007) 1 <input type="checkbox"/> (008) 1 <input type="checkbox"/> (009) 1 <input type="checkbox"/> (010) 1 <input type="checkbox"/> (011) 1 <input type="checkbox"/> (012) 1 <input type="checkbox"/> (013) 1 <input type="checkbox"/> (014) 1 <input type="checkbox"/> (015) 1 <input type="checkbox"/> (016) 1 <input type="checkbox"/> (017) 1 <input type="checkbox"/> (018) 1 <input type="checkbox"/> (019) 1 <input type="checkbox"/> (020) 1 <input type="checkbox"/> (021) 1 <input type="checkbox"/> (022) 1 <input type="checkbox"/> (023) 1 <input type="checkbox"/> (024) 1 <input type="checkbox"/> (025) 1 <input type="checkbox"/> (026) 1 <input type="checkbox"/> (027) 1 <input type="checkbox"/> (028) 1 <input type="checkbox"/> (029) 1 <input type="checkbox"/>	4. CARDIOVASCULAR EVALUATION: <small>If findings, mark applicable box and continue with a. If no findings, SKIP to 5.</small> Yes a. Cyanosis (043) 1 <input type="checkbox"/> b. Irregular pulse (045) 1 <input type="checkbox"/> c. Cardiac murmur (046) 1 <input type="checkbox"/> <small>(Describe: grade, location, radiation, probable valve involved, etc.)</small> _____ _____ _____ d. Other findings - Describe → (047) 1 <input type="checkbox"/> _____ _____ _____	(043) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings Yes (043) 1 <input type="checkbox"/> (045) 1 <input type="checkbox"/> (046) 1 <input type="checkbox"/> (047) 1 <input type="checkbox"/>	
2a. THYROID EVALUATION: <small>(WHO Classification)</small> (030) 1 <input type="checkbox"/> Group 0 2 <input type="checkbox"/> Group 1 3 <input type="checkbox"/> Group 2 4 <input type="checkbox"/> Group 3 b. OTHER THYROID FINDINGS: (031) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings <small>(GO TO 3)</small> R L Both Tenderness (032) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Nodule (033) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Isthmus (034) 1 <input type="checkbox"/> Other - Describe _____ (035) 1 <input type="checkbox"/>	(030) 1 <input type="checkbox"/> Group 0 2 <input type="checkbox"/> Group 1 3 <input type="checkbox"/> Group 2 4 <input type="checkbox"/> Group 3 (031) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings <small>(GO TO 3)</small> R L Both (032) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (033) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (034) 1 <input type="checkbox"/> (035) 1 <input type="checkbox"/>	5. ABDOMINAL EVALUATION: <small>If findings, mark applicable box and continue with a. If no findings, SKIP to 6.</small> Yes a. Hepatomegaly (048) 1 <input type="checkbox"/> b. Splenomegaly (050) 1 <input type="checkbox"/> c. Uterine enlargement (051) 1 <input type="checkbox"/> d. Umbilical hernia (052) 1 <input type="checkbox"/> e. Pot belly (053) 1 <input type="checkbox"/> f. Mass (es) (054) 1 <input type="checkbox"/> 1. Area(s) - Enter number(s) (055) _____ 2. Other findings - Describe (056) 1 <input type="checkbox"/> _____ g. Surgical scars (057) 1 <input type="checkbox"/> 1. Area(s) - Enter number(s) (058) _____ 2. Other findings - Describe (059) 1 <input type="checkbox"/> _____	(048) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings Yes (048) 1 <input type="checkbox"/> (050) 1 <input type="checkbox"/> (051) 1 <input type="checkbox"/> (052) 1 <input type="checkbox"/> (053) 1 <input type="checkbox"/> (054) 1 <input type="checkbox"/> (055) _____ (056) 1 <input type="checkbox"/> (057) 1 <input type="checkbox"/> (058) _____ (059) 1 <input type="checkbox"/>	
3. CHEST EVALUATION <small>If findings, mark applicable box and continue with a. If no findings, SKIP to 4.</small> Yes a. Beading of ribs (037) 1 <input type="checkbox"/> b. Follular hyperkeratosis of upper back (038) 1 <input type="checkbox"/> c. Wheezing on auscultation 1. Diffuse (039) 1 <input type="checkbox"/> 2. Focal (040) 1 <input type="checkbox"/> d. Decreased breath sounds (diffuse) (041) 1 <input type="checkbox"/> e. Other findings - Describe (042) 1 <input type="checkbox"/> _____	(037) 1 <input type="checkbox"/> (038) 1 <input type="checkbox"/> (039) 1 <input type="checkbox"/> (040) 1 <input type="checkbox"/> (041) 1 <input type="checkbox"/> (042) 1 <input type="checkbox"/>	All persons 25 years old or older h. Liver size 1. MCL (040) _____ mm. 2. MSL (041) _____ mm.		
Sample Number _____			Sample Number _____	

<p>6. MUSCULOSKELETAL EVALUATION: If findings, mark applicable box and continue with a. If no findings, SKIP to 7.</p> <p>a. Bowed legs</p> <p>b. Knock knees</p> <p>c. Epiphysial enlargement, wrists</p> <p>d. Other findings - Describe →</p> <p>_____</p> <p>_____</p>	<p>(062) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings</p> <p>Yes</p> <p>(063) 1 <input type="checkbox"/></p> <p>(064) 1 <input type="checkbox"/></p> <p>(065) 1 <input type="checkbox"/></p> <p>(066) 1 <input type="checkbox"/></p>	<p>9. GENERAL EVALUATION: (Conditions which might affect normal growth and development or affect the evaluation of nutrition, such as mongolism, cerebral palsy, dwarfism, parental neglect indicators, etc.)</p> <p>If findings, describe below. If no findings, SKIP to 10.</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>(084) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings</p>
<p>7. NEUROLOGICAL EVALUATION: If findings, mark applicable box and continue with a. If no findings, SKIP to 8.</p> <p>a. Absent knee jerks</p> <p>b. Absent ankle jerks</p> <p>c. Positive Chvostek sign</p> <p>d. Apathy</p> <p>e. Marked hyperirritability</p> <p>f. Other findings - Describe →</p> <p>_____</p> <p>_____</p>	<p>(067) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings</p> <p>Yes</p> <p>(068) 1 <input type="checkbox"/></p> <p>(069) 1 <input type="checkbox"/></p> <p>(070) 1 <input type="checkbox"/></p> <p>(071) 1 <input type="checkbox"/></p> <p>(072) 1 <input type="checkbox"/></p> <p>(073) 1 <input type="checkbox"/></p>	<p>10. SUMMARY OF FINDINGS:</p> <p>a. No findings</p> <p>b. Findings relating to nutrition</p> <p>(List findings) _____</p> <p>_____</p> <p>_____</p>	<p>(085) 1 <input type="checkbox"/></p> <p>(086) 1 <input type="checkbox"/></p>
<p>8. SKIN EVALUATION: If findings, mark applicable box and continue with a. If no findings, SKIP to 9.</p> <p>a. Follicular hyperkeratosis, arms</p> <p>b. Hyperpigmentation, hands and face</p> <p>c. Dry or scaling skin</p> <p>d. Perifolliculosis</p> <p>e. Petechiae - Describe →</p> <p>_____</p> <p>f. Mosaic skin</p> <p>g. Pellagrous dermatitis</p> <p>h. Ecchymoses - Describe →</p> <p>_____</p> <p>i. Other findings - Describe →</p> <p>_____</p> <p>_____</p>	<p>(074) 1 <input type="checkbox"/> Findings 2 <input type="checkbox"/> No findings</p> <p>(075) 1 <input type="checkbox"/></p> <p>(076) 1 <input type="checkbox"/></p> <p>(077) 1 <input type="checkbox"/></p> <p>(078) 1 <input type="checkbox"/></p> <p>(079) 1 <input type="checkbox"/></p> <p>(080) 1 <input type="checkbox"/></p> <p>(081) 1 <input type="checkbox"/></p> <p>(082) 1 <input type="checkbox"/></p> <p>(083) 1 <input type="checkbox"/></p>	<p>c. Other findings, NOT relating to nutrition</p> <p>(List findings)</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p>	<p>(087) 1 <input type="checkbox"/></p> <p>(088) _____</p> <p>(089) _____</p> <p>(090) _____</p> <p>(091) _____</p>
		<p>11. EXAMINER'S SUBJECTIVE IMPRESSION OF NUTRITIONAL STATUS:</p> <p>a. Normal nutrition</p> <p>b. Abnormal nutrition</p>	<p>(092) 1 <input type="checkbox"/></p> <p>2 <input type="checkbox"/></p>
		<p>12. Obesity</p> <p>No obesity</p>	<p>(093) 1 <input type="checkbox"/></p> <p>2 <input type="checkbox"/></p>
		<p>13. Name of physician</p>	<p>Sample Number</p>

HSM-425-7B (PAGE II) REV. 8/71		Form Approved O.M.B. No. 68-R1184	
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY		ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).	
BODY MEASUREMENTS¹			
a. Deck No. 111	b. Examiner No. --	c. Recorder No.	
NOTE Measurement in cm, unless otherwise specified. Measure left side also if the last digit of examinee's sample number is 3 or 6.			
1. Bitrochanteric breadth	1.	(009) ---	
		RIGHT SIDE	LEFT SIDE
2. Elbow breadth	2.	(001) ---	(002) ---
		RIGHT SIDE	LEFT SIDE
3. Upper arm girth	3.	(003) ---	(004) ---
Head and chest circumference (1-7 years)			
4a. Head	4a.	(011) ---	
b. Chest	b.	(012) ---	
		RIGHT SIDE	LEFT SIDE
5. Triceps skinfold (mm.)	5.	(005) ---	(006) ---
		RIGHT SIDE	LEFT SIDE
6. Subscapular skinfold (mm.)	6.	(007) ---	(008) ---
		RIGHT SIDE	LEFT SIDE
7. Sitting height	7.	(010) ---	
8. Is examinee right or left handed?	8.	(016)	<input type="checkbox"/> 1 Right handed <input type="checkbox"/> 2 Left handed <input type="checkbox"/> 3 Uses both hands about the same <input type="checkbox"/> 4 Not sure <input type="checkbox"/> 5 Not applicable
9. Weight (lbs.)	9.	(013) ---	
10a. Standing height (cm.)	10a.	(014) ---	
b. Standing height (inches)		--- /	
NOTES			
			Sample Number

¹The form shown here is for use on nutrition examinees. The form for detailed examinees is identical except for omission of item 4 which is replaced by chest circumference - full inspiration and full expiration.

HEALTH AND NUTRITION EXAMINATION SURVEY

DERMATOLOGY EXAMINATION

Deck No. 151
(USE RED PENCIL TO FILL FORM)

NAME (Last, First, Middle) _____ SAMPLE NUMBER _____ EXAMINER NO. _____ STATE OR FOREIGN COUNTRY OF LONGEST RESIDENCE _____ Years _____

OCCUPATIONAL EXPOSURE 001 Yes 2 No
 IF YES. (CHECK ALL THAT APPLY)
 002 Chemicals, fumes, or vapors 007 Immersion (hands or feet)
 003 Oils 008 Other (SPECIFY) _____
 006 Insecticides

EXPOSURE TO LIGHT (by history)
 009 Unimpressive
 2 Moderate
 3 Considerable

SIGNIFICANT DERMATOLOGICAL DIAGNOSIS FROM THIS EXAMINATION					
Clinical Impression	Code	Biopsy		Biopsy	
		Code	Done	Code	Refused
1. _____	010	011	<input type="checkbox"/> Done <input type="checkbox"/> Not done	012	<input type="checkbox"/> Refused <input type="checkbox"/> Other reason
2. _____	013	014	<input type="checkbox"/> Done <input type="checkbox"/> Not done	015	<input type="checkbox"/> Refused <input type="checkbox"/> Other reason
3. _____	016	017	<input type="checkbox"/> Done <input type="checkbox"/> Not done	018	<input type="checkbox"/> Refused <input type="checkbox"/> Other reason

FINDINGS RELATING TO NUTRITION _____

SIGNIFICANT DERMATOLOGICAL DIAGNOSIS MADE PREVIOUSLY NOW SUPPRESSED OR IN REMISSION	PHOTOGRAPHY OF SKIN Frame No. Lesion diagnosis code 019			
	Code	Certain	Probable	Doubtful
1. _____	020	021 <input type="checkbox"/>	022 <input type="checkbox"/>	023 <input type="checkbox"/>
2. _____	024	025 <input type="checkbox"/>	026 <input type="checkbox"/>	027 <input type="checkbox"/>

GENERAL APPEARANCE (1 - 3)

1. Hair color (Natural) (CHECK 1 BOX)
 028 Gray 1, 2 029 Gray 3, 4
 030 White 031 Black
 032 Dark brown 033 Medium to light brown
 034 Chestnut or auburn 035 Red (kissin, carrot, etc.)
 036 Dark blonde 037 Light blonde

025 Age at first graying, years _____
 Previous Hair Color if Gray or White 026 _____

3. Skin Texture
 038 Surface 1 NO FINDINGS 2 Coarse 3 Fine
 039 Oily 1 Scaling 2 Both 3 None
 040 Dry 1 Senile 2 Wincor 3 Both 4 Atopic Dry

CHECK "YES OR NO" FOR EACH

Dyed, tinted or bleached? 027 Yes 2 No
 Flag signs 028 Yes 2 No

2. Eye Color - (CHECK 1 BOX)
 029 Dark brown 5 Dark blue
 2 Light brown 6 Light blue
 3 Hazel 7 Mismatch
 4 Speckled 8 Other (SPECIFY) _____

Nevus of Iris - (CHECK 1 BOX)
 030 1 Right 2 Left 3 Both

Complexion

Skin Color

Code

Abdomen 039 _____
 Forearm 040 _____
 041 Flaccid 2 Pallid
 042 Erythematous 2 Sallow

4. PIGMENT ABERRATIONS Items 4-6 → 043 NO FINDINGS (GO TO ITEM 7)

Impression

044 Melanin general-hyper 047 Addison's disease
 045 Melanin general-hypo 048 Albinism - Total
 046 Melanin general-cosmetically disfiguring 049 Albinism - Partial

Melanin localized
 050 Face 053 Pellagra pigmentation
 051 Body 054 Vitiligo - Total
 052 Extremities 055 Vitiligo - Partial
 056 Melanin localized - hyper 057 Post-inflammatory
 057 Melanin localized - hypo 058 Chronically ill (ovary)
 058 Melanin localized cosmetically disfiguring 059 Other (SPECIFY) _____

059 Senile depigmentation
 060 Icterus 064 Significant Trauma 2 Surgical 3 Both 4 Herbie Zoster
 061 Tatto - artificial 065 Hypertrophic 1 2 3 4
 062 Tatto - traumatic 066 Atrophic 1 2 3 4
 063 Tatto - traumatic - cosmetically disfig. 067 Keloids 1 2 3 4

5. NEVI Pigmented and related lesions > 1 cm.

Diagnosis (Clinical impression)	Total No.	Size of Largest	Location					
			Face	Scalp and Neck	Both	Extremities	Trunk	Trunk and Extremities
Junctional	067	068	069	070	071	072	073	074
Hutchinsons fr.	075	076	077	078	079	080	081	082
Mong. spot	083	084	085	086	087	088	089	090
Blue nevus	091	092	093	094	095	096	097	098
Nevus of Ota	099	100	101	102	103	104	105	106
Cafe au lait	107	108	109	110	111	112	113	114

6. Vascular

Araneus 093 094 095 096 097 098 099

Flammus 100 101 102 103 104 105

Vasculous 106 107 108 109 110

Cavernous 111 112 113 114

Senile hemangioma 115 116 117 118

VASCULAR CHANGES OTHER THAN NEVI (7 - 10)
 ITEMS 7-10 → 111 1 NO FINDINGS (GO TO ITEM 11)
 7. RAYNAUD'S PHENOMENON
 Source (CHECK ONE) Location (CHECK ONE)
 1 Observed 112 1 Hands 113 1 Purpura-serie 117 1 Coldness
 2 Py history 2 Feet 118 1 Other purpura (CHECK ONE) 118 1 Cyanosis
 3 Both 3 Both 119 1 Traumatic 119 1 Edema
 2 Med. induced 120 1 Dis. related 120 1 Edema, chronic
 4 Idiopathic 2 1 Persistent
 5 Etiology obscure 121 1 Recurrent
 121 1 Gola
 121 1 marmorata

9. ACTINIC DAMAGE →

	Minimal	Moderate	Severe
Overall impression 122	1	2	3
Pingulonecrosis 124	1	2	3
Senile Elastosis 123	1	2	3
Actinic keratosis 125	1	2	3

10. OTHER TELANGIECTASIA

Location
 126 1 Face 129 1 Extremities
 2 Scalp and neck 2 Trunk
 3 Face, scalp, and neck 3 Trunk and extremities

Impression
 130 1 Weber Osler Rondou 133 1 Idiopathic
 131 1 Post irradiation familial
 132 1 Sclerodactyly 134 1 Poikiloderma vasculare atrophicans
 135 1 Other (SPECIFY)

Family history
 136 1 Mother 2 Father 3 Both
 137 1 Paternal 2 Paternal 3 Both
 male female
 138 1 Maternal 2 Maternal 3 Both
 male female

11. MISCELLANEOUS LESIONS OF COLOR AND TEXTURE

139 1 NO FINDINGS (GO TO ITEM 12)

	Few	Many
Clavus (feet) 140	1	2
Seborrheic keratosis		
Face and scalp 141	1	2
Back and chest 142	1	2
Nasolabial or other body folds 143	1	2
Papulosa nigra 144	1	2
Epithelial tags 145	1	2
Neurofibromata 146	1	2
Dermatofibromata 147	1	2
Epidermal nevi 148	1	2
Warts-hands 149	1	2
Warts-feet 150	1	2
Warts-genital 151	1	2
Warts-other (SPECIFY) 152	1	2
Tophi 153	1	2
Xanthomata 154	1	2
Acanthosis nigricans 155	1	2
Lichen striatus 156	1	2

12. NEOPLASTIC CHANGE
 157 1 NO FINDINGS (GO TO ITEM 13)

Malignant	Location						Biopsy Taken		
	Face	Scalp and neck	Both	Trunk	Extrem.	Both			
Basal Cell Epith. 158	1	2	3	159	1	2	3	160	1
Superficial B.C. 161	1	2	3	162	1	2	3	163	1
Squamous Cell Carcinoma 164	1	2	3	165	1	2	3	166	1
Noben's disease 167	1	2	3	168	1	2	3	169	1
Lymphoma, leukemia 170	1	2	3	171	1	2	3	172	1
Metastatic 173	1	2	3	174	1	2	3	175	1
M. F. 176	1	2	3	177	1	2	3	178	1
Other (SPECIFY) 179	1	2	3	180	1	2	3	181	1

Benign

	Size of largest (if > 2, code to 9)
Lipoma 182	cm.
Ganglions 183	cm.
Sebaceous adenoma 184	cm.
Benign neoplasm of sweat glands and ducts 185	cm.
Other fibromata 186	cm.

13. ECTODERMAL APPENDAGES

Eccrine glands → 187 1 NO FINDINGS (GO TO ITEM 14)

Eccrine
 Activity Location
 Marked 188 Forehead 189 Hands 190 Feet
 Minimal 188 2 190 2 190 2
 Dyshydrotic 188 1 190 1 190 1
 193 1 Anhydrotic

Apocrine (post subertal)
 Mammary gland development
 194 1 Absent 2 Marked
 2 Deficient
 Sebaceous glands:
 Sebum production 198 1 Increased
 inclusion cysts (no. 199) 1 < 4 2 3 4
 Largest 200 cm. (9 or > code to 9)
 Location of cysts: → 201 1 Chest 202 1 Face
 203 1 Back 204 1 Other (SPECIFY)

14. NAILS → 205 1 NO FINDINGS (GO TO ITEM 15)

Fingernails (TOTAL NUMBER) 206

Abnormalities (RECORD NUMBER OF NAILS INVOLVED. IF LESS THAN TEN PRECEDE NUMBER WITH 0)

Color 207 _____ White; 208 _____ yellow; 209 _____ Green, brown or black
 Quality 210 _____ Soft; 211 _____ Brittle
 Contour 212 _____ Raised; 213 _____ Spooned
 Surface 214 _____ Rigid; 215 _____ Pitted
 Other 216 _____ Thickened; 217 _____ Clubbed
 Complete absence of nails, not traumatic 218 1
 Bands 219 _____ White, cross; 220 _____ Pigmented long

Clinical impression of abnormalities noted above:
 221 1 Fungus 222 1 Trauma 223 1 Alopecia areata
 224 1 Lichen planus 225 1 Nevus 226 1 Psoriasis
 227 1 Other (SPECIFY)

Toenails

Abnormalities 228 1 Thickened 229 1 Discolored 230 1 Pigmented bands

Clinical impression of abnormalities noted above:
 231 1 Fungus 232 1 Psoriasis 233 1 Nevus
 234 1 Trauma 235 1 Other (SPECIFY)

15. HAIR → 236 1 NO FINDINGS

Scalp: Alopecia	Min.	Mod.	Severe
Male Pattern	237 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Localized	238 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Diffuse	239 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Impression of etiology

240 1 Ataxia 241 1 Infection

242 1 Anci metabo- 243 1 Trauma

244 1 Postcell- 245 1 Familial

macteric

Texture: 246 1 Fine 2 Coarse

247 1 Dry scaring 2 Easily plucked 3 Both

Eyebrows: 248 1 Sparse 2 Absent

Eyelashes: 249 1 Sparse 2 Absent

Facial Hair (post pubertal)

Males

250 1 Sparse 2 Absent

Females

251 1 Excessive

252 1 Alopecia 253 1 Genetically

Ataxia determined

254 1 Post infec- 255 1 Post trauma

tion

256 1 Endocrine 257 1 Other (SPECI-

Fy)

Axillary 258 1 Sparse 2 Absent

Pubic 259 1 Sparse 2 Absent (not shaved)

260 1 Inappropriate escutcheon

Location	None	Minimal	Marked	Excessive
Anterior Thorax	261 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Posterior Thorax	262 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Arms	263 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Legs	264 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
General	265 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

REGIONAL EXAMINATION

16. HEAD AND NECK

266 1 NO FINDINGS (GO TO ITEM 17)

Scalp 267 1 Scaling 2 Erythema 3 Both

Impressions: 268 1 Seborrheic dermatitis

269 1 Trauma

270 1 Psoriasis

271 1 Other

Eyes

Observation	Ever Noticed?		Age of onset	Family History		
	Yes	No		Parents	Sibs	Both
Xanthelasma	272 1 <input type="checkbox"/>	2 <input type="checkbox"/>	273	274 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Arcus senilis	275 1 <input type="checkbox"/>	2 <input type="checkbox"/>	276	277 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Blepharitis (angular)	278 1 <input type="checkbox"/>	2 <input type="checkbox"/>	279	280 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Blepharitis (not angular)	281 1 <input type="checkbox"/>	2 <input type="checkbox"/>	282	283 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hordeolum	284 1 <input type="checkbox"/>	2 <input type="checkbox"/>	285	286 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Chalazion	287 1 <input type="checkbox"/>	2 <input type="checkbox"/>	288	289 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Pterygium	290 1 <input type="checkbox"/>	2 <input type="checkbox"/>	291	292 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Tumor	293 1 <input type="checkbox"/>	2 <input type="checkbox"/>	294	295 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Ears

Deformed 296 1 Acquired 2 Congenital

297 1 Chondrodermatitis helices nodularis

Nose

Deformed 298 1 Acquired 2 Congenital (saddle, etc.)

Mouth

Observation	Lips		Succa		Gingiva		Tongue	
	Yes	No	Yes	No	Yes	No	Yes	No
Fissuring	299 1 <input type="checkbox"/>	300 1 <input type="checkbox"/>	301 1 <input type="checkbox"/>	302 1 <input type="checkbox"/>	303 1 <input type="checkbox"/>	304 1 <input type="checkbox"/>	305 1 <input type="checkbox"/>	306 1 <input type="checkbox"/>
Pigmented les.	307 1 <input type="checkbox"/>	308 1 <input type="checkbox"/>	309 1 <input type="checkbox"/>	310 1 <input type="checkbox"/>	311 1 <input type="checkbox"/>	312 1 <input type="checkbox"/>	313 1 <input type="checkbox"/>	314 1 <input type="checkbox"/>
Leukoplakia	315 1 <input type="checkbox"/>	316 1 <input type="checkbox"/>	317 1 <input type="checkbox"/>	318 1 <input type="checkbox"/>	319 1 <input type="checkbox"/>	320 1 <input type="checkbox"/>	321 1 <input type="checkbox"/>	322 1 <input type="checkbox"/>
Lichen Planus	323 1 <input type="checkbox"/>	324 1 <input type="checkbox"/>	325 1 <input type="checkbox"/>	326 1 <input type="checkbox"/>	327 1 <input type="checkbox"/>	328 1 <input type="checkbox"/>	329 1 <input type="checkbox"/>	330 1 <input type="checkbox"/>
Tumor	331 1 <input type="checkbox"/>	332 1 <input type="checkbox"/>	333 1 <input type="checkbox"/>	334 1 <input type="checkbox"/>	335 1 <input type="checkbox"/>	336 1 <input type="checkbox"/>	337 1 <input type="checkbox"/>	338 1 <input type="checkbox"/>
Angular les. or sore	339 1 <input type="checkbox"/>	340 1 <input type="checkbox"/>	341 1 <input type="checkbox"/>	342 1 <input type="checkbox"/>	343 1 <input type="checkbox"/>	344 1 <input type="checkbox"/>	345 1 <input type="checkbox"/>	346 1 <input type="checkbox"/>
Chelosis	347 1 <input type="checkbox"/>	348 1 <input type="checkbox"/>	349 1 <input type="checkbox"/>	350 1 <input type="checkbox"/>	351 1 <input type="checkbox"/>	352 1 <input type="checkbox"/>	353 1 <input type="checkbox"/>	354 1 <input type="checkbox"/>

Tongue (cont'd.) General macroglossia

Mal developed generally 321 1 Forked 322 1 Partial atrophy 2 Full atrophy

Fapillae 323 1 Atrophic 324 1 Geographic 3 Pyramidal

325 1 Black hairy 4 Scrotal

Falate 326 1 Smokers 2 Glandular hypertrophy 327 1 Arched

328 1 Cleft

329 1 Both

Color 330 1 Beefy red 2 Magenta

Other findings. 331 1 Serrations 2 Swelling (marginal bilateral)

332 1 Both

17. THORAX AND ABDOMEN 333 1 NO FINDINGS (GO TO ITEM 18)

Supernumerary areolae 334 1 number with glandular tissue

335 1 number without glandular tissue

Gynecomastia: 336 1 Minimal 2 Marked

Etiology 337 1 Medication

338 1 Liver dysfunction

339 1 Both

Striae: 340 1 Purple 341 1 White 342 1 Pigmented

343 1 Draining fistulae or other lesions

344 1 Congenital malformations

18. THIGHS AND BUTTOCKS

345 1 NO FINDINGS (GO TO ITEM 19)

346 1 Venous stasis

347 1 Pilonidal cysts-spread

348 1 Pilonidal cysts-drainage

349 1 Pilonidal cysts-no drainage

350 1 Pilonidal cysts-repaired

351 1 Rectal fistula

352 1 Rectal fissure and ulceration

353 1 Both

354 1 Inter-gluteal fissure

19. GENITALIA

355 1 NO FINDINGS (GO TO ITEM 20)

356 1 Chancres Redness and scaling due to:

357 1 Other VD 358 1 Psoriasis

359 1 Both 2 Seborrheic derma-

360 1 Ulcers 361 1 Glands

362 1 Parasites

363 1 Both

364 1 Uncertain

20. EXTREMITIES

365 1 NO FINDINGS (GO TO ITEM 21)

Clubbing 366 1 Acquired 367 1 Deformity

368 1 Deformity, acquired

369 1 Deformity, familial

Variocities 370 1 Right 371 1 Left

372 1 Both

373 1 Uncertain

Follicular hyperkeratosis 374 1 No color change

375 1 Peri-follicular redness

Upper-outer arm 376 1 2

Rest of upper extrem. 377 1 2

Entire arm 378 1 2

Upper-outer legs 379 1 2

Rest of lower extrem. 380 1 2

Entire leg 381 1 2

Upper back 382 1 2

Abdomen 383 1 2

Buttocks 384 1 2

EVALUATION OF DERMATOLOGICAL COMPLAINT

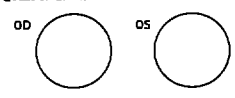
FORM 1 NO CONDITIONS (END OF EXAM)

EVALUATION	LOCATION			TOTAL SKIN COMPLAINT
	HAND	FOOT	OTHER (SPECIFY LOCATION)	
32. Diagnostic Code	(487)	(488)	(489)	
Recurrent?	(490)	(491)	(492)	X
1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	
2 <input type="checkbox"/> No	2 <input type="checkbox"/> No	2 <input type="checkbox"/> No	2 <input type="checkbox"/> No	
IF YES-Months active in past 12 months	(493)	(494)	(495)	
Years duration	(496)	(497)	(498)	
Percent limitation of activity	(499)	(500)	(501)	(502)
33. Handicap to Gainful Employment or Housework				
Total	(503)	(504)	(505)	(506)
Part-severe	1 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Part-minimal	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
None	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
Precludes preferred occupation	(507)	(508)	(509)	(510)
1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Yes
34. Handicap to Social Relations				
Severe	(511)	(512)	(513)	(514)
Minimal	1 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>
None	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
35. Care Sought (CHECK ALL THAT APPLY)				
Non professional	(515)	(516)	(517)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
Pharmacy	(518)	(519)	(520)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
M.D.	(521)	(522)	(523)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
Podiatrist	(524)	(525)	(526)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
Dentopach	(527)	(528)	(529)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
Dermatologist	(530)	(531)	(532)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
36. Presently Under Current Best Care	(533)	(534)	(535)	
1 <input type="checkbox"/> 2 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/>	
IF NO WITH expert care	(536)	(537)	(538)	
a. Would condition be improved?	1 <input type="checkbox"/> 2 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/>	
b. Would condition permit Full Gain- Emp. or HW	(539)	(540)	(541)	
1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
Part. Emp. or HW	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	
No change	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	

EVALUATION	SEVERITY				
	NONE	MIN.	MOD.	SEVERE	
37. Disfigurement (examiner eval.)					
Hand	(542)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Foot	(543)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other	(544)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
38. Discomfort (Patient evaluation)					
a. Pain or Burning					
Hand	(545)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Foot	(546)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other	(547)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Itching					
Hand	(548)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Foot	(549)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other	(550)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Limitation of Motion					
Hand	(551)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Foot	(552)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other	(553)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Overall Discomfort					
Hand	(554)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Foot	(555)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other	(556)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
39. OBSTACLE TO IMPROVEMENT OF CONDITION (CHECK ALL THAT APPLY)					
(557) 1 <input type="checkbox"/> No medical advice sought					
2 <input type="checkbox"/> Inadequate medical advice					
(558) 1 <input type="checkbox"/> Patient cooperation					
(559) 1 <input type="checkbox"/> Distance from medical help					
(560) 1 <input type="checkbox"/> Availability of transportation					
(561) 1 <input type="checkbox"/> Finances					
(562) 1 <input type="checkbox"/> Other					

I. REFRACTION		Eye	Sphere	Cylinder	Axis	VA	PH
1. Present glasses	OD	035	036	037	038	039	
		1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	_____ °	
	OS	040	041	042	043	044	
		1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	_____ °	
2. If acuity less than 20/40, retinoscopy	OD	045	046	047**	048**	049**	050
		1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	_____ °	_____ c*
	OS	052	053	054**	055**	056**	057
		1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	1 <input type="checkbox"/> + 2 <input type="checkbox"/> -	_____ D	_____ °	_____ c*
* To be entered by coder							
J. LIDS				OD	OS	OU	
1. Blepharitis				039	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
a. Angular				040	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Chalazion				041	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Concretions				042	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Ectropion				043	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Entropion				044	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Hordeolum				045	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Ptosis				046	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Other - Specify _____				047	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. No abnormality				048	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
K. GLOBE				OD	OS	OU	
1. Enucleation				049	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Exophthalmos				070	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
a. Measurement					_____	_____	_____
b. Base					_____	_____	_____
3. Microphthalmos				071	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
a. Measurement (mm)					_____	_____	_____
4. Other - Specify _____				072	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. No abnormality				073	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
L. CONJUNCTIVA				OD	OS	OU	
1. Bitot's spot				074	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Conjunctivitis							
a. Allergic				075	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Follicular				076	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Infectious				077	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(1) Bacterial - Specify _____				078	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Viral - Specify _____				079	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Follicles (no inflammation)				080	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Inclusions				081	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Pingueculum				082	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Xerosis				083	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Other - Specify _____				084	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. No abnormality				085	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
M. SCLERA				OD	OS	OU	
1. Ectasia				086	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Episcleritis				087	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Scleritis				088	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Other - Specify _____				089	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. No abnormality				090	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
NOTES							

** For detailed examiners only.

N. CORNEA		OD	OS	OU
1. Arcus senilis	1. (091) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
2. Band keratopathy	2. (092) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
3. Degeneration - Specify _____	3. (093) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
4. Dystrophy - Specify _____	4. (094) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
5. Edema				
a. Epithelial	5a. (095) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
b. Stromal	5b. (096) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
6. Endothelial KP's	6. (097) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
7. Guttae	7. (098) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
8. Keratitis - Specify _____	8. (099) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
9. Keratomalacia	9. (100) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
10. Krukenberg spindle	10. (101) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
11. Opacity - Specify _____	11. (102) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
a. Superficial stromal	11a. (103) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
12. Pterygium	12. (104) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
13. Vessels - Specify _____	13. (105) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
14. Other - Specify _____	14. (106) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
15. No abnormality	15. (107) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
16. Diagram location of abnormalities	16. (108) 1 <input type="checkbox"/> Location shown			

O. ANTERIOR CHAMBER		OD	OS	OU
1. Cells	1. (109) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
2. Flare	2. (110) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
3. Other - Specify _____	3. (111) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
4. No abnormality	4. (112) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	

P. IRIS		OD	OS	OU
1. Synechiae				
a. Anterior	1a. (113) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
b. Posterior	1b. (114) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
2. Atrophy	2. (115) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
3. Coloboma	3. (116) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
4. Iris	4. (117) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
5. Neovascularization	5. (118) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
6. Other - Specify _____	6. (119) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
7. No abnormality	7. (120) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	

Q. LENS		OD	OS	OU
1. Aphakia	1. (121) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
2. Cataract				
a. Immature	2a. (122) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
b. Intumescent	2b. (123) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
c. Mature	2c. (124) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
d. Hypermature	2d. (125) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
e. Morgagnian	2e. (126) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
3. Opacity				
a. Anterior polar	3a. (127) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
b. Cortical	3b. (128) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
c. Nuclear	3c. (129) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
d. Post subcapsular	3d. (130) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
4. Pigment on surface	4. (131) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
5. Other - Specify _____	5. (132) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
6. No abnormality	6. (133) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	

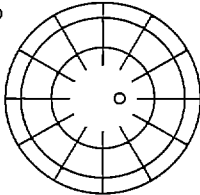
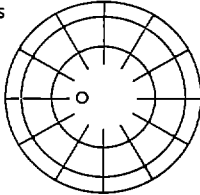
R. VITREOUS		OD	OS	OU
1. Detachment	1. (134) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
2. Hemorrhage	2. (135) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
3. Opacity - Specify _____	3. (136) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
4. Other - Specify _____	4. (137) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
5. No abnormality	5. (138) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	

5. RETINA		OD	OS	OU
1. Disc				
a. Drusen	1a.	(137) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Glaucomatous cup	b.	(140) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Neovascularization	c.	(141) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Optic atrophy				
(1) Primary	d(1)	(142) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Secondary	(2)	(143) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Papilledema	e.	(144) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Papillitis	f.	(145) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g. Other - Specify _____				
	g.	(146) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Macula				
a. Degeneration				
(1) Senile	2a(1)	(147) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Disciform	(2)	(148) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3) Circinate	(3)	(149) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Diabetic involvement	b.	(150) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Edema	c.	(151) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Hypertensive involve	d.	(152) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Pigment epith. detach	e.	(153) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Other - Specify _____				
	f.	(154) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Vessels				
a. Arteries				
(1) Branch occlusion	3a(1)	(155) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Central occlusion	(2)	(156) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3) Gen. narrow (1-4)	(3)	(157) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4) Sclerosis (1-4)	(4)	(158) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Veins				
(1) Branch occlusion	b(1)	(159) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Central occlusion	(2)	(160) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3) Dilatation	(3)	(161) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4) Sausaging	(4)	(162) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(5) Sheathing	(5)	(163) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(6) Tortuosity	(6)	(164) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Capillaries				
(1) Microaneurysms	c(1)	(165) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Neovascularization	(2)	(166) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Other - Specify _____				
	d.	(167) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Exudates				
a. Cotton wool	4a.	(168) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Hard	b.	(169) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Waxy	c.	(170) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Other - Specify _____				
	d.	(171) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Hemorrhages				
a. Choroidal	5a.	(172) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Preretinal	b.	(173) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Retinal				
(1) Deep	c(1)	(174) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Superficial	(2)	(175) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Other - Specify _____				
	d.	(176) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Pigment changes				
a. Choroidal	6a.	(177) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Epithelial				
(1) Atrophy	b(1)	(178) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Hyperplasia	(2)	(179) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Other - Specify _____				
	c.	(180) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Angioid streaks	7.	(181) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Detachments	8.	(182) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Drusen	9.	(183) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
10. Inflammation				
a. Choroiditis - Specify _____				
	10a.	(184) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(1) Active	(1)	(185) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Inactive	(2)	(186) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
11. Retrolental fibroplasia	11.	(187) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
12. Other - Specify _____				
	12.	(188) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
13. No abnormality	13.	(189) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
14. Not visualized	14.	(190) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

S. RETINA - Continued

15. Diagram location of retinal abnormalities

(191) Location shown

OD  OS 

T. OPHTHALMIC DIAGNOSIS

(192) Incomplete examination
 No abnormality
 Abnormality

Code	Mark column applicable, leave blank if unknown						
	Condition decreases vision	Treatment			Eye affected		
		Needed	Under care	Not needed	OD	OS	OU
193 1. Amblyopia <input type="checkbox"/> Present	194 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	195 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	196 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	197 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	198 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	199 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	200 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
2. _____ _____	201 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	202 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	203 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	204 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	205 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	206 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	207 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
3. _____ _____	208 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	209 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	210 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	211 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	212 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	213 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	214 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
4. _____ _____	215 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	216 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	217 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	218 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	219 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	220 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	221 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
5. _____ _____	222 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	223 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	224 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	225 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	226 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	227 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	228 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
6. _____ _____	229 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	230 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	231 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	232 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	233 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	234 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	235 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>

NOTES

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
ROCKVILLE MARYLAND 20852

Confidentiality has been assured the individual as set forth in 22 FR 1687

HEALTH AND NUTRITION EXAMINATION SURVEY IV
DENTAL EXAMINATION

NAME										STAND AND CONTROL																			
AGE										EXAMINEE																			
SEX-RACE																													
UPPER LEFT					UPPER RIGHT					LOWER LEFT					LOWER RIGHT														
10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
										CENTRAL																			
OCC					OCC					OCC					OCC														
LIN					LIN					LIN					LIN														
BUC					BUC					BUC					BUC														
MES					MES					MES					MES														
DIS					DIS					DIS					DIS														
										LATERAL																			
OCC					OCC					OCC					OCC														
LIN					LIN					LIN					LIN														
BUC					BUC					BUC					BUC														
MES					MES					MES					MES														
DIS					DIS					DIS					DIS														
										BUCCAL																			
OCC					OCC					OCC					OCC														
LIN					LIN					LIN					LIN														
BUC					BUC					BUC					BUC														
MES					MES					MES					MES														
DIS					DIS					DIS					DIS														
										1ST BILATERAL																			
OCC					OCC					OCC					OCC														
LIN					LIN					LIN					LIN														
BUC					BUC					BUC					BUC														
MES					MES					MES					MES														
DIS					DIS					DIS					DIS														
										2ND BILATERAL																			
OCC					OCC					OCC					OCC														
LIN					LIN					LIN					LIN														
BUC					BUC					BUC					BUC														
MES					MES					MES					MES														
DIS					DIS					DIS					DIS														
										1ST MOLAR																			
OCC					OCC					OCC					OCC														
LIN					LIN					LIN					LIN														
BUC					BUC					BUC					BUC														
MES					MES					MES					MES														
DIS					DIS					DIS					DIS														

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL CENTER FOR HEALTH STATISTICS
ROCKVILLE, MD. 20825
HEALTH AND NUTRITION EXAMINATION SURVEY

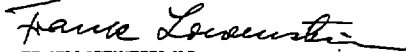
REPORT OF PHYSICAL FINDINGS¹

Dear Doctor:

Recently the person named below was a sample person who voluntarily participated as an examinee in the Health and Nutrition Examination Survey conducted at special facilities of the U.S. Public Health Service. The objectives of the Survey are to obtain information on the nutritional and general health status of the U.S. population. The examination is not, and was not intended to be, a substitute for a visit to the examinee's physician, nor was it intended to be a complete examination. At the request of the examinee, however, we do send a report of certain selected procedures to his/her physician.

Reported below are physical findings which our physicians (including an ophthalmologist and a dermatologist) thought were significant and should be brought to your attention (i.e., for which no treatment had been sought and/or no history given). Also reported are some test reports and/or laboratory data. Although we are not engaged in follow-up or treatment of our findings, we appreciate the cooperation of our examinees and hope that we can contribute to their medical care by making this information available to you.

Sincerely,



FRANK LOWENSTEIN, M.D.
Nutrition Advisor

Form Approved: O.M.B. No. 68-R1184

Examinee's name and address _____ _____		Date of examination	Age	Height
			Sex	Weight
MEDICAL <input type="checkbox"/> No new significant findings	DERMATOLOGICAL <input type="checkbox"/> No new significant findings	OPHTHALMOLOGICAL <input type="checkbox"/> No new significant findings		VISUAL ACUITY R Eye L Eye 20/____ 20/____ <input type="checkbox"/> Without glasses <input type="checkbox"/> With glasses <input type="checkbox"/> With contacts <input type="checkbox"/> Not tested
Hematocrit _____ vol%		URINE	Neg	Tr
Hemoglobin _____ gm%		Albumin		
RBC count _____ mil/cc		Sugar		
WBC count _____ thou/cc		Ph <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9		
Sed rate _____ mm/hr		Hematest <input type="checkbox"/> Pos <input type="checkbox"/> Neg		

SEE REVERSE SIDE FOR NOTES ON TESTS AND PROCEDURES

¹This form is used for reporting significant findings of examinees receiving only the nutrition component. The form reproduced on page 76 is used for reporting findings of examinees receiving the detailed component.

NOTES ON TESTS AND PROCEDURES

Medical Examination - A physician, a dermatologist, an ophthalmologist, and a dentist examined each examinee. The physician's examination included the head and neck, chest (cardiopulmonary), abdomen, and extremities (musculoskeletal and neurological) -- however, rectal, pelvic, and breast examinations were excluded. The dermatologist's examination supplemented the physician's skin examination. The ophthalmologist's examination included visual acuity, slit lamp and ophthalmoscopic visualization, and tonometry on examinees age 20 and over.

Urinalysis - Dip and read method using Ames Hema-Combistix.

Hematology - Screening limits ***

Determination	Micro-hematocrit Vol. %	Cyanmet-hemoglobin Hgb Gm%	Coulter counter RBC/cc	Coulter counter WBC/cc	Wintrobe Sed Rate mm/hr
Age 1	≥ 31	≥ 10.0	3.8 - 5.2 mill.	7.0 - 16.0 thou.	-
Ages 2 - 11	≥ 34	≥ 11.0	3.8 - 5.2 mill.	6.0 - 15.0 thou.**	-
Males 12 - 16 yrs.*	≥ 39	≥ 13.0	4.5 - 5.5 mill.	4.5 - 10.0 thou.	-
Females 12 - 16 yrs.	≥ 36	≥ 11.5	4.2 - 5.2 mill.	4.5 - 10.0 thou.	-
Adult Males	41 - 52	14.0 - 16.5	4.6 - 6.2 mill.	4.3 - 10 thou.	0 - 9
Adult Females	36 - 48	12.0 - 14.5	4.2 - 5.4 mill.	4.3 - 10 thou.	0 - 20
Pregnant Females	33 - 42	10.5 - 14.0	3.7 - 4.9 mill.	5.0 - 12.0 thou.	0 - 30

* Marked variation with age for hematocrit, hemoglobin, and red blood cells for males in puberty.

** Marked variation with age for white blood cells in age group 2 - 11.

*** Results outside the screening limits are considered to warrant further investigation of the examinee

Clinical Chemistry - Laboratory tests on blood and urine are performed by a central laboratory. Results shown below, if any, are those received from the laboratory prior to the time this report was mailed and which were outside the screening limits *** indicated. If additional results outside the screening limits are received, they will be forwarded to you promptly. Otherwise, you will know that all values were within the screening limits.

BLOOD

Test	Result	Screening limits ***	Test	Result	Screening limits ***
Vitamin A (P)	___ ug %	20 - 100 ug %	Total protein (S)	___ gms %	5.0 - 8.5 gms %
Iron (S)	___ ug %	40 - 200 ug %	Albumin (S)	___ gms %	3.0 - 5.5 gms %
I.B.C. (S)	___ ug %	240 - 400 ug %	Cholesterol	___ mg %	260 or less
Folate (S)	___ mug %	5 - 30 mug %	Iodine (U)	___ ug/gm ___ creat.	50 ug or more
Vitamin C (P)	___ mg %	0.2 - 10.0 mg %	(P) = Plasma	(S) = Serum	(U) = Urine

APPENDIX IIP. NUTRITIONAL BIOCHEMICAL LAB DATA FORM (ALL EXAMINEES)

HSM 425-5A
REV. 6-71

HEALTH AND NUTRITION EXAMINATION SURVEY

CDC-NUTRITIONAL BIOCHEMICAL LAB. - DATA

CARD	SAMPLE NO.	RACE SEX	AGE		EXAMINATION DATE			HOUR OF COLLECTION		HEMATOCR.	HEMOGLOB. GMS %
			YEARS	MONTHS	MONTH	DAY	YEAR				
B01									1 <input type="checkbox"/> AM 2 <input type="checkbox"/> PM	---	---
(1 - 3)	(4 - 8)	(9)	(10 - 11)	(12 - 13)	(14 - 15)	(16 - 17)	(18 - 19)	(20 - 21)	(22)	(23 - 25)	(26 - 28)

Hours since last meal: (29, 30) _____

Physical activity in past 24 hours: (47) 1 None 2 Light 3 Mod. 4 Heavy

Last meal was (31) 1 Light 2 Mod. 3 Heavy

Has examines taken within last 30 days:

Vitamins (32) 1 No 2 Yes → last taken (33, 34) _____ Days _____

Minerals (35) 1 No 2 Yes → last taken (36, 37) _____

Aspirin (38) 1 No 2 Yes → last taken (39, 40) _____

Diuretics (41) 1 No 2 Yes → last taken (42, 43) _____

Other medication prescribed by doctor: (44) 1 No 2 Yes

Last taken in days (45-46) _____

Type of prescribed or other medication _____

Date shipped _____	
# of blood vials shipped 0 1 2 3 4 5 6 7 8 9 10	# of urine vials shipped 0 1
REMARKS-NURSE	REMARKS-LABORATORY
Factors that might affect nutrit. stat. at time of exam:	

RACE-SEX CODE	
1-WM	4-WF
2-NM	5-NF
3-OM	6-OF

APPENDIX IIQ. EXAMINATION FORMS (ADDITIONAL FOR DETAILED EXAMINEES)

HSM-425-1A REV. 11/71		DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION NATIONAL CENTER FOR HEALTH STATISTICS HEALTH AND NUTRITION EXAMINATION SURVEY CONTROL RECORD				Form Approved O.M.B. No. 48-R-1184 ASSURANCE OF CONFIDENTIALITY All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purpose (22 FR 1687).	
a. Name (Last, first, middle)			b. Deck No. 201	c. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female			
d. Date of birth	e. Age	f. Examination date		g. Temperature			
Month Day Year		Month Day Year	Month Day Year	(002)			
PROCEDURE	Time		NOT DONE	STAFF	Procedure or part of overall procedure not done (Enter reason for non-completion)		
	IN	OUT					
1. Casual specimen	(003)	(004)	x <input type="checkbox"/>				
2. Body measurements	(005)	(006)	x <input type="checkbox"/>				
3. X-rays	(007)	(008)	x <input type="checkbox"/>		PREGNANT (009) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
4. Physician's examination	(010)	(011)	x <input type="checkbox"/>				
5. Venipuncture	(012)	(013)	x <input type="checkbox"/>				
6. Tuberculin test	(014)	(015)	x <input type="checkbox"/>				
7. Dermatology	(016)	(017)	x <input type="checkbox"/>				
8. Ophthalmology I	(018)	(019)	x <input type="checkbox"/>				
9. Ophthalmology II	(020)	(021)	x <input type="checkbox"/>				
10. Dental examination	(022)	(023)	x <input type="checkbox"/>				
11. Audiometry	(024)	(025)	x <input type="checkbox"/>				
12. ECG and Spiro	(026)	(027)	x <input type="checkbox"/>		ECG	SPIRO	
13. Lung analyzer	(028)	(029)	x <input type="checkbox"/>				
14. Goniometry	(030)	(031)	x <input type="checkbox"/>				
15. Nutrition questionnaire	(032)	(033)	x <input type="checkbox"/>		IN HOME (034) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
16a. Supplement A	(035)	(036)	x <input type="checkbox"/>				
b. Supplement B	(037)	(038)	x <input type="checkbox"/>				
c. Supplement C	(039)	(040)	x <input type="checkbox"/>				
17. Health care needs	(041)	(042)	x <input type="checkbox"/>				
18. General well-being	(043)	(044)	x <input type="checkbox"/>				
OFFICE USE ONLY	TIME IN		TIME OUT		Sample Number		
(081) N <input type="checkbox"/> (091) N <input type="checkbox"/>							

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
HEALTH AND NUTRITION EXAMINATION SURVEY

GENERAL MEDICAL EXAMINATION

ASSURANCE OF CONFIDENTIALITY
All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

Deck No. **232**

A. EXTERNAL EAR (Except canal)

	Right	Left
1. No findings - SKIP to B 1.	(001) 1 <input type="checkbox"/>	(002) 1 <input type="checkbox"/>
2. Findings - Continue with 3 . . . 2.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
3. Operative scar . . . 3.	(003) 1 <input type="checkbox"/>	(004) 1 <input type="checkbox"/>
4. Other - Describe . 4.	(005) 1 <input type="checkbox"/>	(006) 1 <input type="checkbox"/>

5. Pierced ears 5.	(007) 1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No

B. AUDITORY CANAL

	Right	Left
1. No findings - SKIP to C 1.	(008) 1 <input type="checkbox"/>	(009) 1 <input type="checkbox"/>
2. Findings - Continue with 3 . . . 2.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
3. Occluded:		
a. Partially 3a.	(010) 1 <input type="checkbox"/>	(011) 1 <input type="checkbox"/>
b. Completely b.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
4. Occluded by:		
a. Cerumen 4a.	(012) 1 <input type="checkbox"/>	(013) 1 <input type="checkbox"/>
b. Other - Describe b.	2 <input type="checkbox"/>	2 <input type="checkbox"/>

C. DRUM

	Right	Left
1. No findings - SKIP to D 1.	(014) 1 <input type="checkbox"/>	(015) 1 <input type="checkbox"/>
2. Findings - Continue with 4 . . . 2.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
3. Not visible 3.	3 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Dull (Opaque) 4.	(016) 1 <input type="checkbox"/>	(017) 1 <input type="checkbox"/>
5. Transparent 5.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
6. Bulging 6.	(018) 1 <input type="checkbox"/>	(019) 1 <input type="checkbox"/>
7. Retracted 7.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
8. Calcium plaques . . 8.	(020) 1 <input type="checkbox"/>	(021) 1 <input type="checkbox"/>
9. Other findings - Describe 9.	(022) 1 <input type="checkbox"/>	(023) 1 <input type="checkbox"/>

C. DRUM - Continued

	Right	Left
10. Red 10.	(024) 1 <input type="checkbox"/>	(025) 1 <input type="checkbox"/>
11. Other discolorations 11.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
12. Fluid 12.	(026) 1 <input type="checkbox"/>	(027) 1 <input type="checkbox"/>
13. Scars 13.	(028) 1 <input type="checkbox"/>	(029) 1 <input type="checkbox"/>
14. Perforated		
a. With discharge 14a.	(030) 1 <input type="checkbox"/>	(031) 1 <input type="checkbox"/>
b. Without discharge b.	2 <input type="checkbox"/>	2 <input type="checkbox"/>

D. NARES

	Right	Left
1. No findings - SKIP to E 1.	(032) 1 <input type="checkbox"/>	(033) 1 <input type="checkbox"/>
2. Findings - Continue with 3 . . . 2.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
3. Obstruction		
a. Acute 3a.	(034) 1 <input type="checkbox"/>	(035) 1 <input type="checkbox"/>
b. Chronic b.	2 <input type="checkbox"/>	2 <input type="checkbox"/>
4. Other significant findings -		
a. Deviated septum . 4a.	(036) 1 <input type="checkbox"/>	(037) 1 <input type="checkbox"/>
b. Swollen turbinates b.	(038) 1 <input type="checkbox"/>	(039) 1 <input type="checkbox"/>
c. Chronic inflammation c.	(040) 1 <input type="checkbox"/>	(041) 1 <input type="checkbox"/>
d. Other - Describe . d.	(042) 1 <input type="checkbox"/>	(043) 1 <input type="checkbox"/>

E. NECK

1. No findings - SKIP to F 1.	(044) 1 <input type="checkbox"/>
2. Findings - Continue with 3 . . . 2.	2 <input type="checkbox"/>
3. Adenopathy 3.	(045) 1 <input type="checkbox"/>
4. Tracheal deviation. 4.	(046) 1 <input type="checkbox"/>
5. Other - Describe . . 5.	(047) 1 <input type="checkbox"/>

Sample Number

F. CHEST		Dimin. brth. sounds	Absent b.s.	Bronchial b.s.	Rales	Rhonchi	Wheeze
1. Auscultation							
(048) 1 <input type="checkbox"/> No findings — SKIP to G 2 <input type="checkbox"/> Findings	Right chest						
	Upper lobe	(049) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(050) 1 <input type="checkbox"/>	(051) 1 <input type="checkbox"/>	(052) 1 <input type="checkbox"/>	(053) 1 <input type="checkbox"/>
	Middle lobe	(054) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(055) 1 <input type="checkbox"/>	(056) 1 <input type="checkbox"/>	(057) 1 <input type="checkbox"/>	(058) 1 <input type="checkbox"/>
	Lower lobe	(059) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(060) 1 <input type="checkbox"/>	(061) 1 <input type="checkbox"/>	(062) 1 <input type="checkbox"/>	(063) 1 <input type="checkbox"/>
Left chest							
Upper lobe	(064) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(065) 1 <input type="checkbox"/>	(066) 1 <input type="checkbox"/>	(067) 1 <input type="checkbox"/>	(068) 1 <input type="checkbox"/>	
Lower lobe	(069) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	(070) 1 <input type="checkbox"/>	(071) 1 <input type="checkbox"/>	(072) 1 <input type="checkbox"/>	(073) 1 <input type="checkbox"/>	

2. Other chest findings

(074) 1 None 2 Findings _____

G. HEART

1. P.M.I. 1.

(075) 1 Felt 2 Not felt

2. Interspace 2.

(076) 4 5 6 7

3. Midclavicular line 3.

(077) 1 At 2 Inside 3 Outside

4. Thrills 4.

(078) 1 Absent 2 Present

 a. Systolic a.

(079) 1 Base 2 Apex

 b. Diastolic b.

(080) 1 Base 2 Apex

5. Heart sounds

 a. 1st heart sound 5a.

(081) 1 Normal 2 Accentuated 3 Diminished

 b. 2nd heart sound b.

(082) 1 Normal 2 Accentuated 3 Diminished

6. Murmurs 6.

(083) 1 None — Skip to 7

 a. Type a.

SYSTOLIC MURMUR(S)	DIASTOLIC MURMUR(S)
(084) 1 <input type="checkbox"/> Functional	(085) 1 <input type="checkbox"/> Functional
2 <input type="checkbox"/> Organic	2 <input type="checkbox"/> Organic
9 <input type="checkbox"/> Don't know	9 <input type="checkbox"/> Don't know

 b. Location

(1) Apex b(1)

GRADE	GRADE
(086) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>	(087) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>

(2) Midprecordium (2)

(088) 1 2 3 4 5 6 (089) 1 2 3 4 5 6

(3) Left base (3)

(090) 1 2 3 4 5 6 (091) 1 2 3 4 5 6

(4) Right base (4)

(092) 1 2 3 4 5 6 (093) 1 2 3 4 5 6

Sample Number

Continue with 6c, "Origin" on Page 3

G. HEART - Continued

6. Murmurs - Continued

c. Origin

		Systolic	Diastolic	Both
(1) Mitral 6c.(1)	(094)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) Aortic (2)	(095)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3) Tricuspid (3)	(096)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4) Pulmonic (4)	(097)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(5) ASD (5)	(098)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(6) VSD (6)	(099)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(7) Other (7)	(100)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(8) Don't know (8)	(101)	9 <input type="checkbox"/>		

7. Other cardiac or cardiovascular findings

- a. Edema 7a.
- b. Other - Describe b.

- c. Neck vein distension c.

(102)	1 <input type="checkbox"/> No - Skip to H	2 <input type="checkbox"/> Yes - Continue with 7a
(103)	1 <input type="checkbox"/>	
(104)	1 <input type="checkbox"/>	
(105)	1 <input type="checkbox"/>	

H. PULSE - ARTERIAL EVALUATION

1. Palpation

- a. Right radial 1a.
- b. Right femoral b.
- c. Right dorsalis pedis c.
- d. Left radial d.
- e. Left femoral e.
- f. Left dorsalis pedis f.

	Normal	Sclerotic	Tortuous	Sclerotic and Tortuous
(106)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(107)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(108)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(109)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(110)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(111)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

2. Pulsations

- a. Right radial 2a.
- b. Right femoral b.
- c. Right dorsalis pedis c.
- d. Other - Describe d.

- e. Left radial e.
- f. Left femoral f.
- g. Left dorsalis pedis g.
- h. Other - Describe h.

	Normal	Diminished	Bounding	Absent
(112)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(113)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(114)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(115)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(116)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(117)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(118)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
(119)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Sample Number

I. KNEES		(120) 1 <input type="checkbox"/> Findings – Continue with 1 2 <input type="checkbox"/> No findings – Skip to J					
1. Bony irregularity		R	L	Both			
a. Genu varum 1a.	(121) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
b. Genu valgum b.	(122) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
c. Genu recurvatum c.	(123) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
d. Fixed flexion d.	(124) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
e. Other – Describe e.	(125) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
<hr/>							
2. Pain on motion		Act.	Pas.	Both	Tenderness		
a. Right medial 2a.	(126) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(127) 1 <input type="checkbox"/>			
b. Right lateral b.	(128) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(129) 1 <input type="checkbox"/>			
c. Right diffuse c.	(130) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(131) 1 <input type="checkbox"/>			
d. Left medial d.	(132) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(133) 1 <input type="checkbox"/>			
e. Left lateral e.	(134) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(135) 1 <input type="checkbox"/>			
f. Left diffuse f.	(136) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(137) 1 <input type="checkbox"/>			
g. Right suprapatellar g.				(138) 1 <input type="checkbox"/>			
h. Left suprapatellar h.				(139) 1 <input type="checkbox"/>			
i. Right infrapatellar i.				(140) 1 <input type="checkbox"/>			
j. Left infrapatellar j.				(141) 1 <input type="checkbox"/>			
<hr/>							
3. Other findings		R	L	Both			
a. Swelling 3a.	(142) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
b. Fluid b.	(143) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
c. Soft tissue proliferation c.	(144) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
d. Subpatellar crepitus d.	(145) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
e. Muscular wasting thigh e.	(146) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
f. Other – Describe f.	(147) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>				
<hr/>							
J. HIPS		(148) 1 <input type="checkbox"/> Findings – Continue with 1 2 <input type="checkbox"/> No findings – Skip to K					
1. Pain on motion		ACTIVE			PASSIVE		
		R	L	Both	R	L	Both
a. Extension 1a.	(149) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(150) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
b. Flexion b.	(151) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(152) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
c. Abduction c.	(153) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(154) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
d. Adduction d.	(155) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(156) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
e. Ext. rot e.	(157) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(158) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
f. Int. rot f.	(159) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(160) 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
<hr/>							
Sample Number							

HHS-93-4 (PAGE II)
REV. 11/71

J. HIPS - Continued
1. Other findings

a. Muscle wasting (gluteal)	1 a.	(161)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Trochanter tenderness	b.	(162)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Groin tenderness	c.	(163)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Other - Describe _____		(164)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

K. JOINTS

(165) 1 No findings - Skip to L
 2 Findings - Describe and continue with 1 _____

Other joints	MANIFESTATIONS												
	Tender		Swelling		Deformity		Limitation		Heberden's nodes	Pain on motion		Other	
1. Shoulder	(166)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(167)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(168)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(169)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L			(170)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(171)
2. Elbow	(172)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(173)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(174)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(175)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(176)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(177)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L
3. Wrist	(178)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(179)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(180)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(181)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(182)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(183)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L
4. Metacarpophalangeal (No. involved)	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		
	(184)	(185)	(186)	(187)	(188)	(189)	(190)	(191)	(192)	(193)	(194)	(195)	
	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	
	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
5. Proximal-interphalangeal (No. involved)	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		
	(196)	(197)	(198)	(199)	(200)	(201)	(202)	(203)	(204)	(205)	(206)	(207)	
	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	
	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
6. Distalinterphalangeal (No. involved)	RIGHT		LEFT		RIGHT		LEFT		RIGHT		LEFT		
	(208)	(209)	(210)	(211)	(212)	(213)	(214)	(215)	(216)	(217)	(218)	(219)	
	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	
	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	2 <input type="checkbox"/>	
	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>	
7. Ankle	(222)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(223)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(224)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(225)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(226)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(227)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L
8. Feet	(228)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(229)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(230)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(231)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L		(232)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L	(233)	1 <input type="checkbox"/> R 3 <input type="checkbox"/> B 2 <input type="checkbox"/> L

<p>L. BACK</p> <p>1. Scoliosis 1.</p> <p>2. Kyphosis 2.</p> <p>3. Lordosis 3.</p> <p>4. Tenderness</p> <p> a. Sciatic notch 4a.</p> <p> b. Sacroiliac b.</p> <p> c. Other - Describe</p> <p>_____</p> <p>_____</p> <p>5. Limitation of motion</p> <p> a. Cervical spine 5a.</p> <p> b. Thoracic spine b.</p> <p> c. Lumbar spine flexion c.</p> <p> d. Lumbar spine, right lateral flexion d.</p> <p> e. Lumbar spine, left lateral flexion e.</p> <p> f. Full extension f.</p> <p>6. Pain on motion 6.</p> <p>7. Flexion 7.</p> <p>8. Extension 8.</p> <p>9. Right lateral bending 9.</p> <p>10. Left lateral bending 10.</p> <p>11. Right rotation 11.</p> <p>12. Left rotation 12.</p>	<p>(234) 1 <input type="checkbox"/> No findings - Skip to M 2 <input type="checkbox"/> Findings - Continue with 1</p> <p>(235) 1 <input type="checkbox"/></p> <p>(236) 1 <input type="checkbox"/></p> <p>(237) 1 <input type="checkbox"/></p> <p>(238) 1 <input type="checkbox"/> R 2 <input type="checkbox"/> L 3 <input type="checkbox"/> Both</p> <p>(239) 1 <input type="checkbox"/> R 2 <input type="checkbox"/> L 3 <input type="checkbox"/> Both</p> <p>(240) 1 <input type="checkbox"/></p> <p>(241) 1 <input type="checkbox"/></p> <p>(242) 1 <input type="checkbox"/></p> <p>(243) 1 <input type="checkbox"/></p> <p>(244) 1 <input type="checkbox"/></p> <p>(245) 1 <input type="checkbox"/></p> <p>(246) 1 <input type="checkbox"/></p> <p>(247) 1 <input type="checkbox"/> Negative 2 <input type="checkbox"/> Positive</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Cervical</th> <th style="width: 15%;">Thoracic</th> <th style="width: 15%;">Low back</th> <th style="width: 15%;">Diffuse</th> <th style="width: 15%;">Uncertain</th> </tr> </thead> <tbody> <tr> <td>(248) 1 <input type="checkbox"/></td> <td>(249) 1 <input type="checkbox"/></td> <td>(250) 1 <input type="checkbox"/></td> <td>(251) 1 <input type="checkbox"/></td> <td>(252) 1 <input type="checkbox"/></td> </tr> <tr> <td>(253) 1 <input type="checkbox"/></td> <td>(254) 1 <input type="checkbox"/></td> <td>(255) 1 <input type="checkbox"/></td> <td>(256) 1 <input type="checkbox"/></td> <td>(257) 1 <input type="checkbox"/></td> </tr> <tr> <td>(258) 1 <input type="checkbox"/></td> <td>(259) 1 <input type="checkbox"/></td> <td>(260) 1 <input type="checkbox"/></td> <td>(261) 1 <input type="checkbox"/></td> <td>(262) 1 <input type="checkbox"/></td> </tr> <tr> <td>(263) 1 <input type="checkbox"/></td> <td>(264) 1 <input type="checkbox"/></td> <td>(265) 1 <input type="checkbox"/></td> <td>(266) 1 <input type="checkbox"/></td> <td>(267) 1 <input type="checkbox"/></td> </tr> <tr> <td>(268) 1 <input type="checkbox"/></td> <td>(269) 1 <input type="checkbox"/></td> <td>(270) 1 <input type="checkbox"/></td> <td>(271) 1 <input type="checkbox"/></td> <td>(272) 1 <input type="checkbox"/></td> </tr> <tr> <td>(273) 1 <input type="checkbox"/></td> <td>(274) 1 <input type="checkbox"/></td> <td>(275) 1 <input type="checkbox"/></td> <td>(276) 1 <input type="checkbox"/></td> <td>(277) 1 <input type="checkbox"/></td> </tr> </tbody> </table>		Cervical	Thoracic	Low back	Diffuse	Uncertain	(248) 1 <input type="checkbox"/>	(249) 1 <input type="checkbox"/>	(250) 1 <input type="checkbox"/>	(251) 1 <input type="checkbox"/>	(252) 1 <input type="checkbox"/>	(253) 1 <input type="checkbox"/>	(254) 1 <input type="checkbox"/>	(255) 1 <input type="checkbox"/>	(256) 1 <input type="checkbox"/>	(257) 1 <input type="checkbox"/>	(258) 1 <input type="checkbox"/>	(259) 1 <input type="checkbox"/>	(260) 1 <input type="checkbox"/>	(261) 1 <input type="checkbox"/>	(262) 1 <input type="checkbox"/>	(263) 1 <input type="checkbox"/>	(264) 1 <input type="checkbox"/>	(265) 1 <input type="checkbox"/>	(266) 1 <input type="checkbox"/>	(267) 1 <input type="checkbox"/>	(268) 1 <input type="checkbox"/>	(269) 1 <input type="checkbox"/>	(270) 1 <input type="checkbox"/>	(271) 1 <input type="checkbox"/>	(272) 1 <input type="checkbox"/>	(273) 1 <input type="checkbox"/>	(274) 1 <input type="checkbox"/>	(275) 1 <input type="checkbox"/>	(276) 1 <input type="checkbox"/>	(277) 1 <input type="checkbox"/>
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<p>M. STRAIGHT-LEG-RAISING TEST</p> <p>1. Right leg 1.</p> <p>2. Left leg 2.</p> <p>3. Increase -</p> <p> a. On ankle (right leg) 3a.</p> <p> b. Dorsiflexion (Left leg)</p>	<p>(278) 1 <input type="checkbox"/> Neg. 2 <input type="checkbox"/> Pos.</p> <p>(280) 1 <input type="checkbox"/> Neg. 2 <input type="checkbox"/> Pos.</p> <p>(279) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>(281) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																																				
<p>N. OTHER SYSTEMS (Reticulo endothelial, G.I., etc.)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>(282) 1 <input type="checkbox"/> No findings - Skip to O 2 <input type="checkbox"/> Findings - Describe →</p>																																				
<table border="1" style="border-collapse: collapse;"> <tr> <td style="width: 100px; height: 40px;">Sample Number</td> </tr> </table>		Sample Number																																			
Sample Number																																					

O. BLOOD PRESSURE

		TIME		SYSTOLIC		DIASTOLIC
1. Recumbent..... 1.	(283)	---	1 <input type="checkbox"/> A.M.	(284) ---	(285) ---	---
2. Sitting..... 2.		---	2 <input type="checkbox"/> P.M.	(287) ---	(288) ---	---

P. SUMMARY OF DIAGNOSTIC IMPRESSIONS

(289) 1 Normal; no abnormal findings
 2 Abnormal; significant findings noted below

		Severity			Certainty (0-9)	ICD code
		Min.	Mod.	Sev.		
1. Cardiovascular						
a. _____ 1a.	(290)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(291) ---	(292) ---
b. _____ 1b.	(293)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(294) ---	(295) ---
c. _____ 1c.	(296)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(297) ---	(298) ---
2. Musculo-skeletal						
a. _____ 2a.	(299)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(300) ---	(301) ---
b. _____ 2b.	(302)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(303) ---	(304) ---
c. _____ 2c.	(305)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(306) ---	(307) ---
3. Respiratory						
a. _____ 3a.	(308)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(309) ---	(310) ---
b. _____ 3b.	(311)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(312) ---	(313) ---
c. _____ 3c.	(314)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(315) ---	(316) ---
4. Other systems - Specify						
a. _____ 4a.	(317)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(318) ---	(319) ---
b. _____ 4b.	(320)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(321) ---	(322) ---
c. _____ 4c.	(323)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(324) ---	(325) ---
5. _____						
a. _____ 5a.	(326)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(327) ---	(328) ---
b. _____ 5b.	(329)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(330) ---	(331) ---
c. _____ 5c.	(332)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(333) ---	(334) ---

Name of physician	Sample Number
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 REV. 11/71

GONIOMETRY

ASSURANCE OF CONFIDENTIALITY
All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

Deck No. 261	Examiner No. _ _	Recorder No.
------------------------	---------------------	--------------

1. ON STOMACH		
a. Extension of right hip 1a.	180 - 160	(001) _ _ _ _
b. Extension of left hip b.	180 - 160	(002) _ _ _ _
2. ON BACK		
a. Extension of right knee 2a.	0	(003) _ _
b. Flexion of right knee b.	180 - 30	(004) _ _ _ _
c. Flexion of right hip c.	180 - 55	(005) _ _ _ _
d. Adduction of right hip d.	0	(006) _ _
e. Abduction of right hip e.	90 - 140	(007) _ _ _ _
f. Extension of left knee f.	0	(008) _ _
g. Flexion of left knee g.	180 - 30	(009) _ _ _ _
h. Flexion of left hip h.	180 - 55	(010) _ _ _ _
i. Adduction of left hip i.	0	(011) _ _
j. Abduction of left hip j.	90 - 140	(012) _ _ _ _
3. SITTING ON TABLE		
a. Internal rotation of right hip 3a.	40 - 90	(013) _ _
b. External rotation of right hip b.	90 - 140	(014) _ _ _ _
c. Internal rotation of left hip c.	90 - 140	(015) _ _ _ _
d. External rotation of left hip d.	40 - 90	(016) _ _

NOTES

Sample Number

RESPIRATORY FUNCTION TESTS

ASSURANCE OF CONFIDENTIALITY
All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

Deck No. 251

Room temperature (001) — — °C

A. SPIROMETER
1. Was test satisfactory? 1.

(002) 1 Yes 2 No — Explain →

B. SINGLE BREATH DIFFUSING CAPACITY
1. Inspired Co. 1.
2. Small spirometer temperature 2.
3a. Uncorrected barometric pressure 3a.
 b. Barometer temperature b.
4. Inspired helium 4.
5. Expired helium percent 5.
6. Expired Co meter reading 6.
7. Breath holding time *cm 7.
8. Volume inspired V.C. (ATPS) ml 8.
9. Was test satisfactory? 9.

1 0 0 %
(003) — — °C
(004) — — — — mm. Hg.
(021) — — °C
TRIAL #1 TRIAL #2 TRIAL #3
(005) — — — — (010) — — — — (015) — — — —
(006) — — — — (011) — — — — (016) — — — —
(007) — — — — (012) — — — — (017) — — — —
(008) — — — — (013) — — — — (018) — — — —
(009) — — — — (014) — — — — (019) — — — —
(020) 1 Yes 2 No — Explain →

* From tracing — 1/2 inspiration point measured to onset of expiration

NOTES

Sample Number

HSM-425-10
REV. 11/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
HEALTH AND NUTRITION EXAMINATION SURVEY

AUDIOMETRY

Form Approved
O.M.B. No. 68-R1184

ASSURANCE OF CONFIDENTIALITY
All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

Deck No.

241

Audio No.

001

Examiner No.

002

START HERE IF SAMPLE NO. EVEN

AIR CONDUCTION - RIGHT EAR			BONE CONDUCTION - LEFT EAR					
Retest R with masking on L*	Frequency (Hz)	Hearing level	MASKING on R for B/C			Hearing levels (L) - If tone heard in R but not in L, record and circle R - level in space; if tone not heard in R or L, record 55 +		
			HL + 30 (a)	HL + 40 (b)	HL + 50 (c)			
003	1000	004	005	/	/	006	007	008
009	2000	010	011	/	/	012	013	014
015	4000	016	017	/	/	018	019	020
021	500	022	023	/	/	024	025	026
027	1000	028	029	/	/	030	/	/

START HERE IF SAMPLE NO. ODD

AIR CONDUCTION - LEFT EAR			BONE CONDUCTION - RIGHT EAR					
Retest L with masking on R*	Frequency (Hz)	Hearing level	MASKING on L for B/C			Hearing levels (R) - If tone heard in L but not R, record and circle L - level in space; if tone not heard in L or R, record 55 +		
			HL + 30 (a)	HL + 40 (b)	HL + 50 (c)			
031	1000	032	033	/	/	034	035	036
037	2000	038	039	/	/	040	041	042
043	4000	044	045	/	/	046	047	048
049	500	050	051	/	/	052	053	054
055	1000	056	057	/	/	058	/	/

Condition affecting test results (Check only one)

- 059 1 None
 2 Cold or sinusitis now
 3 Ear discharge
 4 Ringing or other noises in ears
 5 Equipment defect **
 6 Cold or sinusitis within one week
 7 Earache within week
 8 Other - Describe **

* Retest poorer ear with A/C masking on better ear only if differences in A/C-HL between the two ears is 40 dB or more

** Specify frequencies affected and describe _____

Sample Number

HSM-425-2
REV. 11/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
HEALTH AND NUTRITION EXAMINATION SURVEY

T B SKIN TEST

Form Approved
O.M.B. No. 68-R1184

ASSURANCE OF CONFIDENTIALITY
All information which would permit identification of the individual will be held strictly confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any other purposes (22 FR 1687).

Name (Last, first, middle)

Deck No.

221

Tuberculin administrator

Date (Month, day, year)

____ - ____ - ____

1. Site injected

1.

(001)

1 Volar forearm

2 Other _____

2. Millimeter induration

2a.

(002)

a. PPD-S (L.A.)

b. PPD-B (R.A.)

b.

(003)

3. Reader

3.

Month Day Year

4. Date read

4.

(004)

____ - ____ - ____

5. Where read?

5.

(005)

1 Home

2 Work

3 Exam center

4 Other

NOTES

Sample Number

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE
 NATIONAL CENTER FOR HEALTH STATISTICS
 ROCKVILLE, MD. 20852
 HEALTH AND NUTRITION EXAMINATION SURVEY

REPORT OF PHYSICAL FINDINGS

Dear Doctor:

Recently the person named below was a sample person who voluntarily participated as an examinee in the Health and Nutrition Examination Survey conducted at special facilities of the U.S. Public Health Service. The objectives of the Survey are to obtain information on the nutritional and general health status of the U.S. population. The examination is not, and was not intended to be, a substitute for a visit to the examinee's physician, nor was it intended to be a complete examination. At the request of the examinee, however, we do send a report of certain selected procedures to his/her physician.

Reported below are physical findings which our physicians (including an ophthalmologist and a dermatologist) thought were significant and should be brought to your attention (i.e., for which no treatment had been sought and/or no history given). Also reported are some test reports and/or laboratory data. Although we are not engaged in follow-up or treatment of our findings, we appreciate the cooperation of our examinees and hope that we can contribute to their medical care by making this information available to you.

Sincerely,

Arnold Engel

Arnold Engel, M.D.
 Medical Advisor

Examinee's name and address	_____		Date of examination	Age	Height	Chest X-ray	EKG	
	_____			Sex	Weight	<input type="checkbox"/> Encl. <input type="checkbox"/> Not done	<input type="checkbox"/> Encl. <input type="checkbox"/> Not done	
MEDICAL <input type="checkbox"/> No new significant findings	DERMATOLOGICAL <input type="checkbox"/> No new significant findings	OPHTHALMOLOGICAL <input type="checkbox"/> No new significant findings		VISUAL ACUITY				
_____	_____	_____		R Eye	L Eye	20 / ____ 20 / ____		
_____	_____	_____		<input type="checkbox"/> Without glasses				
_____	_____	_____		<input type="checkbox"/> With glasses				
				<input type="checkbox"/> With contacts				
				<input type="checkbox"/> Not tested				
Hematocrit _____ vol %	URINE		Neg	Tr	1	2	3	4
Hemoglobin _____ gm %	Albumin							
RBC count _____ mill/cc	Sugar							
WBC count _____ thou/cc	Ph <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9							
Sed rate _____ mm/hr	Hematest <input type="checkbox"/> Pos <input type="checkbox"/> Neg							
Tuberculin		Audiogram - Decibels				Sample Number		
PPD-S _____ mm Not done _____	CPS	500	1000	2000	4000			
PPD-B _____ mm Not read _____	Right							
	Left							

SEE REVERSE SIDE FOR NOTES ON TESTS AND PROCEDURES

NOTES ON TESTS AND PROCEDURES

Medical Examination - A physician, a dermatologist, an ophthalmologist, and a dentist examined each examinee. The physician's examination included the head and neck, chest (cardiopulmonary), abdomen, and extremities (musculo-skeletal and neurological) - however, rectal, pelvic, and breast examinations were excluded. The dermatologist's examination supplemented the physician's skin examination. The ophthalmologist's examination included visual acuity and refraction, slit lamp and ophthalmoscopic visualization, and tonometry on examinees age 20 and over.

X-Rays and EKG - A 12 lead EKG and A-P plus Lateral Chest X-rays were taken unless contraindicated. Knee and hip plus low back A-P X-rays were taken except on females age 49 or less. Copies enclosed are without interpretation -- HANES interpretations will be made later and used only as survey data.

Hematology - Screening limits*

Determination	Micro-hematocrit Vol. %	Cyanmet-hemoglobin Hgb Gm%	Coulter counter RBC/cc	Coulter counter WBC/cc	Wintrobe Sed Rate mm/hr
Adult Males	41 - 52	14.0 - 16.5	4.6 - 6.2 mill.	4.3 - 10 thou.	0 - 9
Adult Females	36 - 48	12.0 - 14.5	4.2 - 5.4 mill.	4.3 - 10 thou.	0 - 20
Pregnant Females	33 - 42	10.5 - 14.0	3.7 - 4.9 mill.	5.0 - 12 thou.	0 - 30

Urinalysis - Dip and read method using Ames Hema-Combistix.

Tuberculin - The skin test results are reported in mm. of induration observed 48 - 72 hours after the intradermal injections of (1) 5 tuberculin units (intermediate strength) of PPD-S and (2) 5 units of PPD-B (Battey strain antigen). For PPD-S, 0-4 mm. is negative, 10 mm. or more is positive, and if PPD-S is greater than PPD-B, 5 - 9 mm. is positive. (If PPD-B is greater than PPD-S, 5 - 9 mm. is considered negative).

Audiometry - Air conduction readings are reported in decibels with respect to audiometric zero (ISO - 1964), which is considered normal.

ROUGH GUIDELINES FOR dB REPORT AT 500 - 2000 cps.

- 25 dB or less - Hearing normal or more acute
- 30 - 40 dB - Near normal (difficulty with faint speech)
- 45 - 55 dB - Mild (difficulty with normal speech)
- 60 - 70 dB - Moderate (difficulty with loud speech)
- 75 - 100 dB - Severe (hears only amplified speech)
- 105 or more - Profound (usually cannot understand amplified speech)

Clinical Chemistry - Laboratory test on blood and urine are performed by a central laboratory. Results shown below, if any, are those received from the laboratory prior to the time this report was mailed. Additional results, if any, will be forwarded to you promptly when received.

*Results outside the screening limits are considered to warrant further investigation of the examinee

BLOOD

Test	Result	Screening limits *	Test	Result	Screening limits *
Vitamin A (P)	— ug %	20 - 100 ug %	Total bilirubin (S)	— mg %	0.2 - 1.0 mg %
Iron (S)	— ug %	40 - 200 ug %	SGOT (S)	— units	10 - 40 units
I.B.C. (S)	— ug %	240 - 400 ug %	Alk. phos. (S)	— I.U.	30 - 80 I.U. (SMA)
Folate (S)	— mug %	5 - 30 mug%	Uric acid (S)	— mg %	2.5 - 7.0 mg %
Vitamin C (P)	— mg %	0.2 - 10.0 mg %	Calcium (S)	— mg %	9.0 - 11.0 mg %
Total protein (S)	— gms %	5.0 - 8.5 gms %	Phosphorous (SorP)	— mg %	2.5 - 4.8 mg %
Albumin (S)	— gms %	3.0 - 5.5 gms %	Iodine (U)	ug/gm — creat.	50 ug or more
Cholesterol	— mg %	260 or less	(P) = Plasma (S) = Serum (U) = Urine		

VITAL AND HEALTH STATISTICS Series

- Series 1. Programs and Collection Procedures.*—Reports which describe the general programs of the National Center for Health Statistics and its offices and divisions and data collection methods used and include definitions and other material necessary for understanding the data.
- Series 2. Data Evaluation and Methods Research.*—Studies of new statistical methodology including experimental tests of new survey methods, studies of vital statistics collection methods, new analytical techniques, objective evaluations of reliability of collected data, and contributions to statistical theory.
- Series 3. Analytical Studies.*—Reports presenting analytical or interpretive studies based on vital and health statistics, carrying the analysis further than the expository types of reports in the other series.
- Series 4. Documents and Committee Reports.*—Final reports of major committees concerned with vital and health statistics and documents such as recommended model vital registration laws and revised birth and death certificates.
- Series 10. Data From the Health Interview Survey.*—Statistics on illness, accidental injuries, disability, use of hospital, medical, dental, and other services, and other health-related topics, all based on data collected in a continuing national household interview survey.
- Series 11. Data From the Health Examination Survey and the Health and Nutrition Examination Survey.*—Data from direct examination, testing, and measurement of national samples of the civilian noninstitutionalized population provide the basis for two types of reports: (1) estimates of the medically defined prevalence of specific diseases in the United States and the distributions of the population with respect to physical, physiological, and psychological characteristics and (2) analysis of relationships among the various measurements without reference to an explicit finite universe of persons.
- Series 12. Data From the Institutionalized Population Surveys.*—Discontinued effective 1975. Future reports from these surveys will be in Series 13.
- Series 13. Data on Health Resources Utilization.*—Statistics on the utilization of health manpower and facilities providing long-term care, ambulatory care, hospital care, and family planning services.
- Series 14. Data on Health Resources: Manpower and Facilities.*—Statistics on the numbers, geographic distribution, and characteristics of health resources including physicians, dentists, nurses, other health occupations, hospitals, nursing homes, and outpatient facilities.
- Series 20. Data on Mortality.*—Various statistics on mortality other than as included in regular annual or monthly reports. Special analyses by cause of death, age, and other demographic variables; geographic and time series analyses; and statistics on characteristics of deaths not available from the vital records based on sample surveys of those records.
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