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FORM **HIS-1 (1986)**
(7-3-85)

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

NATIONAL HEALTH INTERVIEW SURVEY

1. Book ___ of ___ books	2. R.O. number	3. Sample
4. Segment type <input type="checkbox"/> Area <input type="checkbox"/> Permit <input type="checkbox"/> Block	5. Control number PSU Segment Serial	

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

City _____ State _____ County _____ ZIP code _____

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

City _____ State _____ County _____ ZIP code _____

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

14. Noninterview reason

TYPE A

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

TYPE B

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

TYPE C

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

Fill items 1-6a, 7 and 9 as applicable; 10, 12-15

Fill items 1-6a, 8c if marked; 12-15, send Inter-Comm.

AREA AND BLOCK SEGMENTS

7. YEAR BUILT
 Ask
 Do not ask

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

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

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

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

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

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

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

10. CLASSIFICATION OF LIVING QUARTERS — Mark by observation

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

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

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

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

15. Record of calls

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

16. List column numbers of persons requiring callbacks, and mark appropriately.
 None

Col. No.	SS No.	Section P	SP

17. Record of additional contacts

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

GO TO HOUSEHOLD COMPOSITION PAGE

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

12. Was this interview observed?
1 Yes 2 No

13. Interviewer's name _____ Code _____

A. HOUSEHOLD COMPOSITION PAGE

1

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

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

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

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

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

Probe if necessary:

Does -- usually live somewhere else?

If "Yes," enter names in columns

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

1. First name	Mid. init.	Age
Last name		Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F

2. Relationship **REFERENCE PERSON**

3. Date of birth
 Month _____ Date _____ Year _____

C1

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

C2

LA	IRA	DV	TINJ	TCLL	TR	HSTCOND.

Ask for all persons beginning with column 2:

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

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

A1

REFERENCE PERIODS

2-WEEK PERIOD _____

12-MONTH DATE _____

13-MONTH HOSPITAL DATE _____

A2 ASK CONDITION LIST _____

A3 Refer to ages of all related HH members.

A3

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

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

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

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

Ask for each person in armed forces:

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

4d.

Living at home
 Not living at home

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

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

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

HOSPITAL PROBE

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

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

6a.

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

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

Ask for each child under one:

7a. Was -- born in a hospital?

Ask for mother and child:

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

7a.

1 Yes
 2 No (NP)

b.

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

FOOTNOTES

B. LIMITATION OF ACTIVITIES PAGE

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

B. LIMITATION OF ACTIVITIES PAGE, Continued

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

B. LIMITATION OF ACTIVITIES PAGE, Continued

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

FOOTNOTES

D. RESTRICTED ACTIVITY PAGE PERSON 1

Hand calendar.

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

D1

Refer to age.

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

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

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

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

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

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

Yes 00 No (4)

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

00 None (4) (4)

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

Yes 00 No (4)

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

00 None

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

Yes 00 No (6)

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

00 None (6) (D2)

D2

Refer to 2b and 3b.

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

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

00 None

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

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

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

Yes 00 No (D3)

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

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

00 None

D3

Refer to 2-6.

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

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

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

(Enter condition in C2, THEN 7b)

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

1 Yes (Reask 7a and b) 2 No

FOOTNOTES

E. 2-WEEK DOCTOR VISITS PROBE PAGE

Read to respondent(s):

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

E1	Refer to age.	E1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)
1 a.	<p>During those 2 weeks, how many times did — see or talk to a medical doctor? (Include all types of doctors, such as dermatologists, psychiatrists, and ophthalmologists, as well as general practitioners and osteopaths.) (Do not count times while an overnight patient in a hospital.)</p>	1 a. and b.	00 <input type="checkbox"/> None <input style="width: 50px; height: 20px;" type="text"/> } (NP) Number of times
b.	<p>During those 2 weeks, how many times did anyone see or talk to a medical doctor about — ? (Do not count times while an overnight patient in a hospital.)</p>		
2 a.	<p>(Besides the time(s) you just told me about) During those 2 weeks, did anyone in the family receive health care at home or go to a doctor's office, clinic, hospital or some other place? Include care from a nurse or anyone working with or for a medical doctor. Do not count times while an overnight patient in a hospital.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (3a)</p>		
b.	<p>Who received this care? Mark "DR Visit" box in person's column.</p>	2b.	<input type="checkbox"/> DR Visit
c.	<p>Anyone else? <input type="checkbox"/> Yes (Reask 2b and c) <input type="checkbox"/> No</p>		
	<p>Ask for each person with "DR Visit" in 2b:</p>	d.	<input style="width: 50px; height: 20px;" type="text"/> Number of times
3 a.	<p>(Besides the time(s) you already told me about) During those 2 weeks, did anyone in the family get any medical advice, prescriptions or test results over the PHONE from a doctor, nurse, or anyone working with or for a medical doctor?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (E2)</p>		
b.	<p>Who was the phone call about? Mark "Phone call" box in person's column.</p>	3b.	<input type="checkbox"/> Phone call
c.	<p>Were there any calls about anyone else? <input type="checkbox"/> Yes (Reask 3b and c) <input type="checkbox"/> No</p>		
	<p>Ask for each person with "Phone call" in 3b:</p>	d.	<input style="width: 50px; height: 20px;" type="text"/> Number of calls
E2	Add numbers in 1, 2d, and 3d for each person. Record total number of visits and calls in "2-WK. DV" box in item C1.		

FOOTNOTES

F. 2-WEEK DOCTOR VISITS PAGE

DR VISIT 1

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

PERSON NUMBER _____

F1 Refer to age.

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

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

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

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

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

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

1 a. and b. Month _____ Date _____ OR { 7777 Last week
8888 Week before

c.
 1 Yes (Reask 1a or b and c)
 2 No (Ask 2-5 for each visit)

2.
 01 Telephone
Not in hospital:
 02 Home
 03 Doctor's office
 04 Co. or Ind. clinic
 05 Other clinic
 06 Lab
 07 Other (Specify) _____
Hospital:
 08 O.P. clinic
 09 Emergency room
 10 Doctor's office
 11 Lab
 12 Overnight patient (Next DR visit)
 7-88 Other (Specify) _____

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

c. Type _____ 99 DK

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

e. and f.
 1 GP (4)
 2 Specialist (3g)
 9 DK (4)

g. Kind of specialist _____

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

c. Yes (4b) No
d. Yes (4h) No (4g)
e. Yes No (4g)

f. Condition _____ (Item C2, THEN 4g)
g. Yes No (5)
h. Pregnancy (4e)
 Condition _____ (Item C2, THEN 4g)

5 a.
 0 Telephone in 2 (Next DR visit)
 1 Yes
 2 No (Next DR visit)

b.
 (1) _____
 (2) _____

c.
 Yes (Reask 5b and c)
 No

G. HEALTH INDICATOR PAGE

<p>1a. During the 2-week period outlined in red on that calendar, has anyone in the family had an injury from an accident or other cause that you have not yet told me about?</p> <p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No (2)</p> <hr/> <p>b. Who was this? Mark "Injury" box in person's column.</p> <hr/> <p>c. What was -- injury? Enter injury(ies) in person's column.</p> <hr/> <p>d. Did anyone have any other injuries during that period?</p> <p align="center"><input type="checkbox"/> Yes (Reask 1b, c, and d) <input type="checkbox"/> No</p> <p><i>Ask for each injury in 1c:</i></p> <p>e. As a result of the (injury in 1c) did [---/anyone] see or talk to a medical doctor or assistant (about ---) or did --- cut down on --- usual activities for more than half of a day?</p>	<p>1b. <input type="checkbox"/> Injury</p> <hr/> <p>c. _____ Injury</p> <hr/> <p>e. <input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)</p>
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<p>2. During the past 12 months, {that is, since (12-month date) a year ago} ABOUT how many days did illness or injury keep --- in bed more than half of the day? (Include days while an overnight patient in a hospital.)</p>	<p>2. 000 <input type="checkbox"/> None _____ No. of days</p>
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<p>3a. During the past 12 months, ABOUT how many times did [---/anyone] see or talk to a medical doctor or assistant (about ---)? (Do not count doctors seen while an overnight patient in a hospital.) (Include the (number in 2-WK DV box) visit(s) you already told me about.)</p> <hr/> <p>b. About how long has it been since [---/anyone] last saw or talked to a medical doctor or assistant (about ---)? Include doctors seen while a patient in a hospital.</p>	<p>3a. 000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits</p> <hr/> <p>b. 1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 6 <input type="checkbox"/> Never</p>
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<p>4. Would you say --- health in general is excellent, very good, good, fair, or poor?</p>	<p>4. 1 <input type="checkbox"/> Excellent 4 <input type="checkbox"/> Fair 2 <input type="checkbox"/> Very good 5 <input type="checkbox"/> Poor 3 <input type="checkbox"/> Good</p>
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<p><i>Mark box if under 18.</i></p> <p>5a. About how tall is --- without shoes?</p> <hr/> <p>b. About how much does --- weigh without shoes?</p>	<p>5a. <input type="checkbox"/> Under 18 (NP)</p> <p>_____ Feet _____ Inches</p> <hr/> <p>b. _____ Pounds</p>
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FOOTNOTES

H. CONDITION LISTS 1 AND 2

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

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

1	2																																																																												
<p>1a. Does anyone in the family {read names} NOW have — If "Yes," ask 1b and c.</p> <p>b. Who is this?</p> <p>c. Does anyone else NOW have — Enter condition and letter in appropriate person's column.</p> <p>A. PERMANENT stiffness or any deformity of the foot, leg, fingers, arm, or back? (Permanent stiffness — joints will not move at all.)</p> <p>B. Paralysis of any kind?</p> <hr/> <p>1d. DURING THE PAST 12 MONTHS, did anyone in the family have — If "Yes," ask 1e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have — Enter condition and letter in appropriate person's column.</p> <p><i>C—L are conditions affecting the bone and muscle.</i> <i>M—W are conditions affecting the skin.</i></p>	<p>2a. Does anyone in the family {read names} NOW have — If "Yes," ask 2b and c.</p> <p>b. Who is this?</p> <p>c. Does anyone else NOW have — Enter condition and letter in appropriate person's column.</p> <p><i>A—L are conditions affecting</i> Hearing Vision Speech</p> <p><i>M—AA are impairments.</i></p>																																																																												
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H. CONDITION LISTS 3 AND 4

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

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

3

3a. DURING THE PAST 12 MONTHS, did anyone in the family (read names) have —
If "Yes," ask 3b and c.

b. Who was this?

c. DURING THE PAST 12 MONTHS, did anyone else have —
Enter condition and letter in appropriate person's column.
Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list.
Conditions affecting the digestive system.

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

4

4a. DURING THE PAST 12 MONTHS, did anyone in the family (read names) have —
If "Yes," ask 4b and c.

b. Who was this?

c. DURING THE PAST 12 MONTHS, did anyone else have —
Enter condition and letter in appropriate person's column.
A—B are conditions affecting the glandular system.
C is a blood condition.
D—I are conditions affecting the nervous system.
J—Y are conditions affecting the genito-urinary system.

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

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

H. CONDITION LISTS 5 AND 6

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

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

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

HOSPITAL STAY 1

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

1. **PERSON NUMBER** _____

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

Month	Date	Year
		19__

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

3. 0000 None (Next HS)
____ Nights

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

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

J1 Refer to questions 2, 3, and 2-week reference period.

J1 At least one night in 2-week reference period (Enter condition in C2, THEN 5)
 No nights in 2-week reference period (5)

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

5a. 1 Yes 2 No (6)

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

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

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

c. Yes (Reask 5b and c) No

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

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

FOOTNOTES

1. Name of condition _____

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

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

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

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

- 1 Yes 2 No 9 DK

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

b. What did he or she call it? _____

(Specify)

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

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

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

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

- 1 Yes (5) 2 No

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

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

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

(Specify)

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

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

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

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

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

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

Show the following detail:

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

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

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

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

(Specify) _____

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

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

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

- 1 Malignant 2 Benign 9 DK

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

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

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

Ask probes as necessary:

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

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

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

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

K1

Refer to RD and C2.

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

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

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

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

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

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

Ask if age 5-17:

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

K2

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

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

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

K3

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

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

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

3 Under control (K4)

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

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

K4

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

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

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

14. Where did the accident happen?

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

Mark box if under 18. Under 18 (16)

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

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

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

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

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

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

17a. At the time of the accident what part of the body was hurt?

What kind of injury was it?

Anything else?

Part(s) of body *	Kind of injury

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

b. What part of the body is affected now?

How is -- (part of body) affected?

Is -- affected in any other way?

Part(s) of body *	Present effects **

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

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

L. DEMOGRAPHIC BACKGROUND PAGE

L1	Refer to age.	L1	<input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)
1 a. Did — EVER serve on active duty in the Armed Forces of the United States?		1 a.	1 <input type="checkbox"/> Yes (Mark "AF" box, THEN 1b) 2 <input type="checkbox"/> No (2)
b. When did — serve? <i>Mark box in descending order of priority. Thus, if person served in Vietnam and in Korea mark VN.</i>		b.	1 <input type="checkbox"/> VN 5 <input type="checkbox"/> PVN 2 <input type="checkbox"/> KW 8 <input type="checkbox"/> OS 3 <input type="checkbox"/> WWII 9 <input type="checkbox"/> DK 4 <input type="checkbox"/> WWI
Vietnam Era (Aug. '64 to April '75) VN Korean War (June '50 to Jan. '55) KW World War II (Sept. '40 to July '47) WWII World War I (April '17 to Nov. '18) WWI Post Vietnam (May '75 to present) PVN Other Service (all other periods) OS		c.	<input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)
c. Was — EVER an active member of a National Guard or military reserve unit?		d.	1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK
d. Was ALL of — active duty service related to National Guard or military reserve training?			
2 a. What is the highest grade or year of regular school — has ever attended?		2 a.	00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6 +
b. Did — finish the (number in 2a) [grade/year]?		b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
<i>Hand Card R. Ask first alternative for first person; ask second alternative for other persons.</i>			
3 a. [What is the number of the group or groups which represents — race?]		3 a.	1 2 3 4 5 ▾ _____ (Specify)
What is — race? Circle all that apply 1 — Aleut, Eskimo, or American Indian 4 — White 2 — Asian or Pacific Islander 5 — Another group not listed — Specify 3 — Black		b.	1 2 3 4 5 ▾ _____ (Specify)
b. Which of those groups; that is, (entries in 3a) would you say BEST represents — race?		c.	1 <input type="checkbox"/> W 2 <input type="checkbox"/> B 3 <input type="checkbox"/> O
c. Mark observed race of respondent(s) only.			
<i>Hand Card O.</i>			
4 a. Are any of those groups — national origin or ancestry? (Where did — ancestors come from?)		4 a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
b. Please give me the number of the group.		b.	1 2 3 4 5 6 7
Circle all that apply. 1 — Puerto Rican 5 — Chicano 2 — Cuban 6 — Other Latin American 3 — Mexican/Mexicano 7 — Other Spanish 4 — Mexican American			

L.DEMOGRAPHIC BACKGROUND PAGE, Continued

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

<p>8a. Was the total combined FAMILY income during the past 12 months — that is, yours, (read names, including Armed Forces members living at home) more or less than \$20,000? Include money from jobs, social security, retirement income, unemployment payments, public assistance, and so forth. Also include income from interest, dividends, net income from business, farm, or rent, and any other money income received.</p> <p><i>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</i></p> <p>-----</p> <p><i>Read parenthetical phrase if Armed Forces member living at home or if necessary.</i></p> <p>b. Of those income groups, which letter best represents the total combined FAMILY income during the past 12 months (that is, yours, (read names, including Armed Forces members living at home))? Include wages, salaries, and other items we just talked about.</p> <p><i>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</i></p>	<p>8a.</p> <p><input type="checkbox"/> \$20,000 or more (Hand Card I)</p> <p><input type="checkbox"/> Less than \$20,000 (Hand Card J)</p> <p>b.</p> <table style="width:100%; border: none;"> <tr> <td>00 <input type="checkbox"/> A</td> <td>10 <input type="checkbox"/> K</td> <td>20 <input type="checkbox"/> U</td> </tr> <tr> <td>01 <input type="checkbox"/> B</td> <td>11 <input type="checkbox"/> L</td> <td>21 <input type="checkbox"/> V</td> </tr> <tr> <td>02 <input type="checkbox"/> C</td> <td>12 <input type="checkbox"/> M</td> <td>22 <input type="checkbox"/> W</td> </tr> <tr> <td>03 <input type="checkbox"/> D</td> <td>13 <input type="checkbox"/> N</td> <td>23 <input type="checkbox"/> X</td> </tr> <tr> <td>04 <input type="checkbox"/> E</td> <td>14 <input type="checkbox"/> O</td> <td>24 <input type="checkbox"/> Y</td> </tr> <tr> <td>05 <input type="checkbox"/> F</td> <td>15 <input type="checkbox"/> P</td> <td>25 <input type="checkbox"/> Z</td> </tr> <tr> <td>06 <input type="checkbox"/> G</td> <td>16 <input type="checkbox"/> Q</td> <td>26 <input type="checkbox"/> ZZ</td> </tr> <tr> <td>07 <input type="checkbox"/> H</td> <td>17 <input type="checkbox"/> R</td> <td></td> </tr> <tr> <td>08 <input type="checkbox"/> I</td> <td>18 <input type="checkbox"/> S</td> <td></td> </tr> <tr> <td>09 <input type="checkbox"/> J</td> <td>19 <input type="checkbox"/> T</td> <td></td> </tr> </table>	00 <input type="checkbox"/> A	10 <input type="checkbox"/> K	20 <input type="checkbox"/> U	01 <input type="checkbox"/> B	11 <input type="checkbox"/> L	21 <input type="checkbox"/> V	02 <input type="checkbox"/> C	12 <input type="checkbox"/> M	22 <input type="checkbox"/> W	03 <input type="checkbox"/> D	13 <input type="checkbox"/> N	23 <input type="checkbox"/> X	04 <input type="checkbox"/> E	14 <input type="checkbox"/> O	24 <input type="checkbox"/> Y	05 <input type="checkbox"/> F	15 <input type="checkbox"/> P	25 <input type="checkbox"/> Z	06 <input type="checkbox"/> G	16 <input type="checkbox"/> Q	26 <input type="checkbox"/> ZZ	07 <input type="checkbox"/> H	17 <input type="checkbox"/> R		08 <input type="checkbox"/> I	18 <input type="checkbox"/> S		09 <input type="checkbox"/> J	19 <input type="checkbox"/> T	
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R	<p>a. Mark first appropriate box.</p> <p>-----</p> <p>b. Enter person number of respondent.</p>	<p>Ra.</p> <p><input type="checkbox"/> Under 17</p> <p><input type="checkbox"/> Present for all questions</p> <p><input type="checkbox"/> Present for some questions</p> <p><input type="checkbox"/> Not present</p> <p>b.</p> <p>_____</p> <p>Person number(s) of respondent(s)</p>
L3	<p>Enter person number of first parent listed or mark box.</p>	<p>L3</p> <p>_____</p> <p>Person number of parent</p> <p><input type="checkbox"/> None in household</p>
L4	<p>Enter person number of spouse or mark box.</p>	<p>L4</p> <p>_____</p> <p>Person number of spouse</p> <p><input type="checkbox"/> None in household</p>

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

Read to Hhld. respondent: **The National Center for Health Statistics may wish to contact you again to obtain additional health related information. Please give me the name, address, and telephone number of a relative or friend who would know where you could be reached in case we have trouble reaching you. (Please give me the name of someone who is not currently living in the household.) Please print items 12-15.**

		RT62									
12. Contact Person name	3-4	25-39	40								
Last	5-24	First	Middle initial								
		14. Area code/telephone number									
		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> - <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>									97-106
13a. Address (Number and street)											
		1 <input type="checkbox"/> None 2 <input type="checkbox"/> Refused 9 <input type="checkbox"/> DK									
		107									
b. City	66-85	State	86-87								
		ZIP Code	88-96								
			15. Relationship to household respondent								
			108-109								

FOOTNOTES

Section M. HEALTH INSURANCE

3-4

Read to respondent(s): **Medicare is a Social Security health insurance program for disabled persons and for persons 65 years old and over. People covered by Medicare have a card that looks like this. Show card.**

1a. Is anyone in this family, that is (read names), now covered by Medicare? Yes No (4) DK

b. Is --- now covered?

2a. Is --- now covered by the part of Social Security Medicare which pays for hospital bills?

b. Is --- now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which --- or some agency must pay a certain amount each month.

3. May I please see the Social Security Medicare card(s) for --- (and ---) to determine the type of coverage? Transcribe the information from the card or mark the "Card N.A." box.

4a. We are interested in all kinds of health insurance plans except those which pay only for accidents. (Not counting Medicare) Is anyone in the family now covered by a health insurance plan which pays any part of a hospital, doctor's, surgeon's or dentist's bill? Yes No (M1) DK (M1)

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

c. Is anyone in the family now covered by any other health insurance plan which pays any part of a hospital, doctor's, or dentist's bill? Yes (Reask 4b and c) No

TABLE H.I.

PLAN 1 NAME										10	7. Is --- covered under this (name) plan?			17				
5a. Is this (name) plan a Health Maintenance Organization or HMO?	Yes	No	DK	11	6a. Does this (name) plan pay any part of hospital expenses?	Yes	No	DK	14	7. Is --- covered under this (name) plan?	1	2	9	16	7. } (NP)			
	1	2	9			1	2	9								2	9	
	1	2 (6a)	9 (6a)			1	2	9								9	DK	
b. Was this plan obtained through an employer or union?	1	2	9	12	b. Does this plan pay any part of doctor's or surgeon's bills for operations?	1	2	9	15	7. Is --- covered under this (name) plan?	1	2	9	16	7. } (NP)			
	1	2	9			1	2	9								2	9	
	1	2	9			1	2	9								9	DK	
c. Is it now carried through an employer or union?	1	2	9	13	c. Does it pay for any DENTAL services other than oral surgery?	1	2	9	16	7. Is --- covered under this (name) plan?	1	2	9	16	7. } (NP)			
	1	2	9			1	2	9								2	9	
	1	2	9			1	2	9								9	DK	
PLAN 2 NAME										18	7. Is --- covered under this (name) plan?			25				
5a. Is this (name) plan a Health Maintenance Organization or HMO?	Yes	No	DK	19	6a. Does this (name) plan pay any part of hospital expenses?	Yes	No	DK	22	7. Is --- covered under this (name) plan?	1	2	9	24	7. } (NP)			
	1	2	9			1	2	9								1	2	9
	1	2 (6a)	9 (6a)			1	2	9								9	DK	
b. Was this plan obtained through an employer or union?	1	2	9	20	b. Does this plan pay any part of doctor's or surgeon's bills for operations?	1	2	9	23	7. Is --- covered under this (name) plan?	1	2	9	24	7. } (NP)			
	1	2	9			1	2	9								1	2	9
	1	2	9			1	2	9								9	DK	
c. Is it now carried through an employer or union?	1	2	9	21	c. Does it pay for any DENTAL services other than oral surgery?	1	2	9	24	7. Is --- covered under this (name) plan?	1	2	9	24	7. } (NP)			
	1	2	9			1	2	9								1	2	9
	1	2	9			1	2	9								9	DK	
PLAN 3 NAME										26	7. Is --- covered under this (name) plan?			33				
5a. Is this (name) plan a Health Maintenance Organization or HMO?	Yes	No	DK	27	6a. Does this (name) plan pay any part of hospital expenses?	Yes	No	DK	30	7. Is --- covered under this (name) plan?	1	2	9	32	7. } (NP)			
	1	2	9			1	2	9								1	2	9
	1	2 (6a)	9 (6a)			1	2	9								9	DK	
b. Was this plan obtained through an employer or union?	1	2	9	28	b. Does this plan pay any part of doctor's or surgeon's bills for operations?	1	2	9	31	7. Is --- covered under this (name) plan?	1	2	9	32	7. } (NP)			
	1	2	9			1	2	9								1	2	9
	1	2	9			1	2	9								9	DK	
c. Is it now carried through an employer or union?	1	2	9	29	c. Does it pay for any DENTAL services other than oral surgery?	1	2	9	32	7. Is --- covered under this (name) plan?	1	2	9	32	7. } (NP)			
	1	2	9			1	2	9								1	2	9
	1	2	9			1	2	9								9	DK	

Section M. HEALTH INSURANCE, Continued

<p>11a. There is a national program called Medicaid which pays for health care for persons in need. (In this State it is also called <i>(name)</i>.) During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid (or <i>(name)</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No (12) <input type="checkbox"/> DK</p>	<p>11b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 61 2 <input type="checkbox"/> No</p>
<p>b. Has --- received this care in the past 12 months?</p>	
<p>12a. Does anyone in the family now have a Medicaid (or <i>(name)</i>) card which looks like this? Show Medicaid card(s). <input type="checkbox"/> Yes <input type="checkbox"/> No (13) <input type="checkbox"/> DK</p>	
<p>b. Does --- now have this card?</p>	<p>12b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 62 2 <input type="checkbox"/> No</p>
<p>Ask for each person with "Yes" in 12b:</p> <p>c. May I please see --- (and ---) card(s)? Mark appropriate box(es) in person's column.</p>	<p>c. <input type="checkbox"/> Medicaid card seen ▾ 63 1 <input type="checkbox"/> Current 2 <input type="checkbox"/> Expired 3 <input type="checkbox"/> No card seen 8 <input type="checkbox"/> Other card seen ▾ _____ Specify</p>
<p>13a. Is anyone in the family now covered by any other public assistance program that pays for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No (14) <input type="checkbox"/> DK</p>	
<p>b. Is --- now covered?</p>	<p>13b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 64 2 <input type="checkbox"/> No</p>
<p>14a. Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans' Administration? Do not include VA disability compensation. <input type="checkbox"/> Yes <input type="checkbox"/> No (15) <input type="checkbox"/> DK</p>	
<p>b. Does --- now receive military retirement or a VA pension?</p>	<p>14b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 65 2 <input type="checkbox"/> No</p>
<p>Ask for each person with "Yes" in 14b:</p> <p>c. Which does --- receive — the Armed Forces retirement, the VA pension or both?</p>	<p>c. 1 <input type="checkbox"/> Armed Forces 66 2 <input type="checkbox"/> VA 3 <input type="checkbox"/> Both</p>
<p>15a. Is anyone in the family now covered by CHAMPUS, which is a program of medical care for dependents of military personnel? <input type="checkbox"/> Yes <input type="checkbox"/> No (15c) <input type="checkbox"/> DK</p>	
<p>b. Is --- now covered by CHAMPUS?</p>	<p>15b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 67 2 <input type="checkbox"/> No</p>
<p>c. Is anyone in the family now covered by CHAMP-VA, which is medical insurance for dependents or survivors of disabled veterans? <input type="checkbox"/> Yes <input type="checkbox"/> No (16) <input type="checkbox"/> DK</p>	
<p>d. Is --- now covered by CHAMP-VA?</p>	<p>d. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 68 2 <input type="checkbox"/> No</p>
<p>16a. Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons? <input type="checkbox"/> Yes <input type="checkbox"/> No (M2) <input type="checkbox"/> DK</p>	
<p>b. Is --- now covered?</p>	<p>16b. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK 69 2 <input type="checkbox"/> No</p>

Section M. HEALTH INSURANCE, Continued

M2	Refer to "AF" box above person's column.	M2	1 <input type="checkbox"/> AF box marked (17) 8 <input type="checkbox"/> Other (NP)	70															
17a. Does --- have a disability related to --- service in the Armed Forces of the United States?		17a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)		71															
b. Does --- now receive compensation for this disability from the Veterans' Administration?		b. 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No		72															
c. Has --- ever applied for a service-connected disability rating from the Veterans' Administration?		c. 1 <input type="checkbox"/> Yes 9 <input type="checkbox"/> DK (NP) 2 <input type="checkbox"/> No (NP)		73															
d. Was it approved or denied?		d. 1 <input type="checkbox"/> Approved 3 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Denied 9 <input type="checkbox"/> DK		74															
18a. During the past 12 months, that is since [12-month date] a year ago, have [read names of related HH members 18 or over] been laid off from a job or lost a job? <input type="checkbox"/> Yes <input type="checkbox"/> No (Supplement Booklet) <input type="checkbox"/> DK (Supplement Booklet)				75															
b. Who was this? Mark "Laid off/lost job" box in person's column.		18b. 1 <input type="checkbox"/> Laid off/lost job																	
c. Anyone else? <input type="checkbox"/> Yes (Reask 18b and c) <input type="checkbox"/> No Ask 18d, e, and f for each person with "Laid off/lost job" in 18b.				76															
d. How many times has --- been laid off or lost a job during the past 12 months?		d. _____ Times																	
e. In what month and year was --- laid off or did --- lose a job [(the last time/the time before that)]?		e. <table style="margin-left: 20px; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; padding: 2px;">Mo.</td> <td style="border: 1px solid black; padding: 2px;">Yr.</td> <td style="padding: 2px;">Time 1</td> <td style="border: 1px solid black; padding: 2px;">19__</td> <td style="padding: 2px;">77-80</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Mo.</td> <td style="border: 1px solid black; padding: 2px;">Yr.</td> <td style="padding: 2px;">Time 2</td> <td style="border: 1px solid black; padding: 2px;">19__</td> <td style="padding: 2px;">81-84</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Mo.</td> <td style="border: 1px solid black; padding: 2px;">Yr.</td> <td style="padding: 2px;">Time 3</td> <td style="border: 1px solid black; padding: 2px;">19__</td> <td style="padding: 2px;">85-88</td> </tr> </table>		Mo.	Yr.	Time 1	19__	77-80	Mo.	Yr.	Time 2	19__	81-84	Mo.	Yr.	Time 3	19__	85-88	
Mo.	Yr.	Time 1	19__	77-80															
Mo.	Yr.	Time 2	19__	81-84															
Mo.	Yr.	Time 3	19__	85-88															
f. For ANYTIME during [that/those] job layoff(s) or job loss(es), did --- receive unemployment insurance benefits?		f. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		89															
19a. Because of [names of persons in 18b] job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through [that/those] job(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Supplement Booklet) <input type="checkbox"/> DK (Supplement Booklet)				90															
b. Who was this? Mark "Lost coverage" box in person's column.		19b. 1 <input type="checkbox"/> Lost coverage																	
c. Anyone else? <input type="checkbox"/> Yes (Reask 19b and c) <input type="checkbox"/> No																			
M3	Refer to 19b and mark appropriate box.	M3	1 <input type="checkbox"/> Lost coverage (20) 2 <input type="checkbox"/> Did not lose coverage (NP)	91															
20a. For ANYTIME during [that/those] job layoff(s) or job loss(es), was --- without any type of health insurance coverage? [Do not include health care programs, such as Medicaid, AFDC, or military benefit programs, as health insurance coverage.]		20a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (21)		92															
b. For how long was --- without some type of health insurance coverage? (How many months is that?)		b. 00 <input type="checkbox"/> Less than 1 month _____ Months		93-94															
21a. For ANYTIME during [that/those] job layoff(s) or job loss(es), was --- covered by any health care program, such as Medicaid, AFDC, or a military benefit program?		21a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)		95															
b. For how long was --- covered by some health care program? (How many months is that?)		b. 00 <input type="checkbox"/> Less than 1 month _____ Months		96-97															

