

Appendix III Questionnaires and Flashcards

Book ___ of ___ books	Batch number RT 10	Coder status 8			OMB No. 0920-0214; Approval Expires 03/31/97																																																																	
<p>Notice - Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to average 30 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Office, ATTN: PRA (0920-0214), Huser 4, Humphrey Building, Room 737-F, 200 Independence Avenue, SW, Washington, DC 20201.</p>																																																																						
1. RO 9-10	2. Sample 11-13	3. Week 14	4. Segment type 15-16	HIS-1 (1996) U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE																																																																		
5. Control number PSU Segment Suffix Serial Suffix Check digit 17-21 22-26 26-27 28-29 30 31			6. Screening status 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 32																																																																			
7a. What is your exact address? (Including House No., Apt. No., or other identification; county and ZIP Code)			15. Neighbor screening results (Mark if "S" in item 6)																																																																			
City _____ State _____ County _____ ZIP Code _____ Line No. _____			0 <input type="checkbox"/> Neighbors not contacted 1 <input type="checkbox"/> Screened out by neighbors 2 <input type="checkbox"/> Eligible per neighbor 3 <input type="checkbox"/> Undetermined by neighbors																																																																			
b. Is this your mailing address? (Mark box or specify if different; include county and ZIP Code)			16. Noninterview reason																																																																			
City _____ State _____ County _____ ZIP Code _____ Line No. _____			TYPE A 01 <input type="checkbox"/> Refused 02 <input type="checkbox"/> No one home, repeated calls 03 <input type="checkbox"/> Temporarily absent 04 <input type="checkbox"/> Language problem 05 <input type="checkbox"/> Other (Specify) _____ Indicate best estimate of race/ethnicity for each Type A 1 <input type="checkbox"/> Black/Hispanic 2 <input type="checkbox"/> Not Black/Hispanic 3 <input type="checkbox"/> Unknown																																																																			
c. GQ name			TYPE B 06 <input type="checkbox"/> Vacant, nonseasonal 07 <input type="checkbox"/> Vacant, seasonal 08 <input type="checkbox"/> Occupied entirely by URE 09 <input type="checkbox"/> Occupied entirely by AF members 10 <input type="checkbox"/> Occupied - screened out by household 11 <input type="checkbox"/> Occupied - screened out by neighbors 12 <input type="checkbox"/> Unfit or to be demolished 13 <input type="checkbox"/> Under construction - not ready 14 <input type="checkbox"/> Converted to temporary business or storage 15 <input type="checkbox"/> Unoccupied site for mobile home, trailer, or tent 16 <input type="checkbox"/> Permit granted - construction not started 17 <input type="checkbox"/> Other (Specify) _____																																																																			
8. YEAR BUILT (Area segments only)			TYPE C 18 <input type="checkbox"/> Unused line of listing sheet 19 <input type="checkbox"/> Demolished 20 <input type="checkbox"/> House or trailer moved 21 <input type="checkbox"/> Outside segment boundaries 22 <input type="checkbox"/> Converted to permanent business or storage 23 <input type="checkbox"/> Merged 24 <input type="checkbox"/> Condemned 25 <input type="checkbox"/> Built after April 1, 1990 26 <input type="checkbox"/> Other (Specify) _____																																																																			
9. COVERAGE QUESTIONS			17. Record of calls																																																																			
a. Are there any other living quarters - either occupied or vacant - in this building? b. Are there any other living quarters - either occupied or vacant - on this floor? c. Is there any other building, mobile home, or trailer - either occupied or vacant - on this property for people to live in?			<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Month</th> <th>Date</th> <th>Beginning time</th> <th>Ending time</th> <th>Completed (X)</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>1</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>2</td><td></td><td>F a.m.</td><td>a.m.</td><td></td></tr> <tr><td>2</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>3</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>3</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>4</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>4</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>5</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>5</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>6</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>6</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> </tbody> </table>			Month	Date	Beginning time	Ending time	Completed (X)	1		P a.m.	a.m.		1		T p.m.	p.m.		2		F a.m.	a.m.		2		T p.m.	p.m.		3		P a.m.	a.m.		3		T p.m.	p.m.		4		P a.m.	a.m.		4		T p.m.	p.m.		5		P a.m.	a.m.		5		T p.m.	p.m.		6		P a.m.	a.m.		6		T p.m.	p.m.	
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10a. LAND USE			18. List column numbers of persons requiring callbacks, and indicate reason(s).																																																																			
1 <input type="checkbox"/> URBAN (11) 2 <input type="checkbox"/> RURAL - Reg. units and G.Q. units coded 92-N or 93-N in 7c - Ask item 10b - GQ units not coded 92-N or 93-N in 7c - Mark "No" in item 10b without asking			Person No. S.S. No. Other Person No. S.S. No. Other																																																																			
b. During the past 12 months, did sales of crops, livestock, and other farm products from this place amount to \$1,000 or more?			19. Record of additional contacts																																																																			
1 <input type="checkbox"/> Yes (11) 2 <input type="checkbox"/> No			<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Month</th> <th>Date</th> <th>Beginning time</th> <th>Ending time</th> <th>Completed Person No.</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>1</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>2</td><td></td><td>F a.m.</td><td>a.m.</td><td></td></tr> <tr><td>2</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>3</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>3</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> <tr><td>4</td><td></td><td>P a.m.</td><td>a.m.</td><td></td></tr> <tr><td>4</td><td></td><td>T p.m.</td><td>p.m.</td><td></td></tr> </tbody> </table>			Month	Date	Beginning time	Ending time	Completed Person No.	1		P a.m.	a.m.		1		T p.m.	p.m.		2		F a.m.	a.m.		2		T p.m.	p.m.		3		P a.m.	a.m.		3		T p.m.	p.m.		4		P a.m.	a.m.		4		T p.m.	p.m.																					
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11. CLASSIFICATION OF LIVING QUARTERS - Mark by observation			13. Interview observed?																																																																			
a. LOCATION of unit Unit is: 1 <input type="checkbox"/> In Group Quarters - Refer to GQ Table on pages 4-7 through 4-15 of the 11-8, FR Listing and Coverage Manual; then complete 11c or d 2 <input type="checkbox"/> NOT in Group Quarters (11b)			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																			
b. Access 1 <input type="checkbox"/> Direct (11c) 2 <input type="checkbox"/> 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.)			14a. Field representative's name																																																																			
c. HOUSING unit (Mark one) 01 <input type="checkbox"/> House, apartment, flat 02 <input type="checkbox"/> HU in nontransient hotel, motel, etc. 03 <input type="checkbox"/> HU-permanent in transient hotel, motel, etc. 04 <input type="checkbox"/> HU in rooming house 05 <input type="checkbox"/> Mobile home or trailer with no permanent room added 06 <input type="checkbox"/> Mobile home or trailer with one or more permanent rooms added 07 <input type="checkbox"/> HU not specified above - Describe _____			b. Language of interview 1 <input type="checkbox"/> English 2 <input type="checkbox"/> Spanish 3 <input type="checkbox"/> Both English and Spanish 4 <input type="checkbox"/> Other																																																																			
d. GROUP QUARTERS (GQ) unit (Mark one) 08 <input type="checkbox"/> Quarters not HU in rooming or boarding house 09 <input type="checkbox"/> Unit not permanent in transient hotel, motel, etc. 10 <input type="checkbox"/> Unoccupied site for mobile home, trailer, or tent 11 <input type="checkbox"/> Student quarters in college dormitory 12 <input type="checkbox"/> GQ unit not specified above - Describe _____			14b. Language of interview																																																																			
12a. What is the telephone number here?			13. Interview observed?																																																																			
0 <input type="checkbox"/> None Area code/number _____			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																			
b. Is there any working telephone located INSIDE your home?			14a. Field representative's name																																																																			
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			Code _____																																																																			

Old age Cov. In name

A. HOUSEHOLD COMPOSITION PAGE		1																																														
<p>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.</p> <p>b. What are the names of all other persons living or staying here? Enter names in columns.</p> <p>c. I have listed (read names). Have I missed:</p> <ul style="list-style-type: none"> — 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? 		<p>1. First name _____ Mid. init. _____ Age _____</p> <p>Last name _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>2. Relationship _____</p> <p>3. REFERENCE PERSON</p> <p>Date of birth _____</p> <p>Month _____ I Date _____ I Year _____</p>																																														
<p>d. Do all of the persons you have named usually live here? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (APPLY HOUSEHOLD MEMBERSHIP RULES. Delete nonhousehold members by an "X" from 1-C2 and enter reason.)</p> <p>Probe if necessary: _____</p> <p>Does -- usually live somewhere else? _____</p> <p>Ask for all persons beginning with column 2: _____</p>		<p>C1</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>HOSP.</td> <td>WORK</td> <td>RD</td> <td>2-WK. DV</td> </tr> <tr> <td>00 <input type="checkbox"/> None</td> <td>1 <input type="checkbox"/> Wa</td> <td>1 <input type="checkbox"/> Yes</td> <td>00 <input type="checkbox"/> None</td> </tr> <tr> <td>Number</td> <td>2 <input type="checkbox"/> Wb</td> <td>2 <input type="checkbox"/> No</td> <td>Number</td> </tr> </table>		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																																	
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Number	2 <input type="checkbox"/> Wb	2 <input type="checkbox"/> No	Number																																													
<p>2. What is -- relationship to (reference person)?</p> <p>3. What is -- date of birth? (Enter date and age and mark sex.)</p>		<p>C2</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>LA</td> <td>RA</td> <td>DV</td> <td>T</td> <td>INJ.</td> <td>CL</td> <td>LTR</td> <td>HS</td> <td>COND.</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		LA	RA	DV	T	INJ.	CL	LTR	HS	COND.																																				
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REFERENCE PERIODS																																																
A1	2-WEEK PERIOD _____																																															
	12-MONTH DATE _____																																															
	13-MONTH HOSPITAL DATE _____																																															
A2	ASK CONDITION LIST _____																																															
A3	Refer to ages of all HH members.	A3	<input type="checkbox"/> All persons 65 and over (5) <input type="checkbox"/> Other (4a)																																													
<p>4a. Are any of the persons in this household now on full-time active duty with the armed forces? <input type="checkbox"/> Yes (4b) <input type="checkbox"/> No (5)</p> <p>b. Who is this? Mark "AF member" box in person's column</p> <p>c. Anyone else? <input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No (4d)</p> <p>Ask for each person with "AF member" box marked in 4b.</p> <p>d. Where does -- usually live and sleep, here or somewhere else? Mark box in person's column.</p>		<p>4b. <input type="checkbox"/> AF member</p> <p>4d. <input type="checkbox"/> Living at home (Exclude from health questions) <input type="checkbox"/> Not living at home (Delete from household by an "X" from 1-C2)</p>																																														
<p>5a. Are any of those groups -- National origin or ancestry? (Where did -- ancestors come from?)</p> <p>b. Please give me the number of the group. Circle all that apply.</p> <p>1 - Puerto Rican 3 - Mexican/Mexicano 5 - Chicano 7 - Other Spanish 2 - Cuban 4 - Mexican American 6 - Other Latin American</p>		<p>5a. 1 <input type="checkbox"/> Yes (5b) 2 <input type="checkbox"/> No (NP)</p> <p>b. 1 2 3 4 5 6 7</p>																																														
<p>6a. [What is the number of the group or groups which represents -- race? (What is -- race?)]</p> <p>Circle all that apply.</p> <p>1 - White 4 - Eskimo 6 - Chinese 10 - Vietnamese 14 - Guamanian 2 - Black/African American 5 - Aleut 7 - Filipino 11 - Japanese 15 - Other API - Specify 3 - Indian (American) 8 - Hawaiian 9 - Korean 12 - Asian Indian 16 - Other race - Specify</p> <p>ASK IF MULTIPLE ENTRIES IN 6a:</p> <p>b. Which of those groups, that is, (entries in 6a) would you say BEST represents -- race?</p> <p>c. Mark observed race of respondent(s) only.</p>		<p>6a. 1 2 3 4 5 6 7 8 9</p> <p>10 11 12 13 14 15 16</p> <p>_____ (Specify)</p> <p>b. 1 2 3 4 5 6 7 8 9</p> <p>10 11 12 13 14 15 16</p> <p>_____ (Specify)</p> <p>c. 1 <input type="checkbox"/> W 2 <input type="checkbox"/> B 3 <input type="checkbox"/> O</p>																																														
A4	Refer to item 6 "Status" on the Household Page.	A4	<input type="checkbox"/> S (Item A5) <input type="checkbox"/> I (Next page)																																													
A5	Refer to 5a and 6a above for all household members. Mark (X) first appropriate box.	A5	<input type="checkbox"/> Any "Yes" in 5a (Next page) <input type="checkbox"/> Any "2" in 6a (Next page) <input type="checkbox"/> All others (7)																																													
<p>7. Enter person number of the respondent and then read:</p> <p style="text-align: center;">Not every household in our survey is asked all questions. I have all the information about your household that I need at this time.</p> <p style="text-align: center;">END INTERVIEW</p>		<p>Person number _____ Respondent</p>																																														

INTRODUCTION AND HOSPITAL PROBE	
<p><i>If related persons 17 and over are listed in addition to the respondent and are not present, say:</i> 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)</p>	
<p><i>Read to respondent(s):</i> 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.</p>	
HOSPITAL PROBE	
<p>1a. Since (13-month hospital date) a year ago, was -- a patient in a hospital OVERNIGHT?</p>	<p>1a. 1 <input type="checkbox"/> Yes (1b) 2 <input type="checkbox"/> No (Mark "HOSP." box, THEN NP)</p>
<p>b. How many different times did -- stay in any hospital overnight or longer since (13-month hospital date) a year ago?</p>	<p>b. _____ } (Make entry in "HOSP." box THEN NP) Number of times</p>
<p><i>Ask for each child under one:</i></p> <p>2a. Was -- born in a hospital?</p>	
<p>----- <i>Ask for mother and child:</i></p> <p>b. Have you included this hospitalization in the number you gave me for --?</p>	<p>2a. 1 <input type="checkbox"/> Yes (2b) 2 <input type="checkbox"/> No (NP)</p> <p>b. 1 <input type="checkbox"/> Yes (NP) 2 <input type="checkbox"/> No (Correct 1 and "HOSP." box)</p>
<p>FOOTNOTES</p>	

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

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

D. RESTRICTED ACTIVITY PAGE PERSON 1

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

D1 Refer to age.
 Under 5 (4) 5-17 (3) 18 and over (1)

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 oo 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?
 oo None (4) (4)

3 a. During those 2 weeks, did -- miss any time from school because of illness or injury?
 Yes oo 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?
 oo None

4 a. During those 2 weeks, did -- stay in bed because of illness or injury?
 Yes oo 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?
 oo 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?
 oo 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 oo 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?
 oo 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			
<i>Read to respondent:</i> These next questions are about health care received during the 2 weeks outlined in red on that calendar.			
E1	<i>Refer to age.</i>	E1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)
1a. During those 2 weeks, how many times did -- see or talk to a medical doctor? (Include all types of doctors, such as dermatologists, psychiatrists, and ophthalmologists, as well as general practitioners and osteopaths.) (Do not count times while an overnight patient in a hospital.) b. During those 2 weeks, how many times did anyone see or talk to a medical doctor about --? (Do not count times while an overnight patient in a hospital.)		1a. and b.	<input type="checkbox"/> None <input style="width: 50px; height: 20px;" type="text"/> } (NP) Number of times
2a. (Besides the time(s) you just told me about) During those 2 weeks, did anyone in the family receive health care at home or go to a doctor's office, clinic, hospital or some other place? Include care from a nurse or anyone working with or for a medical doctor. Do not count times while an overnight patient in a hospital. <input type="checkbox"/> Yes <input type="checkbox"/> No (3a)			
b. Who received this care? Mark "DR Visit" box in person's column.		2b.	<input type="checkbox"/> DR Visit
c. Anyone else? <input type="checkbox"/> Yes (Reask 2b and c) <input type="checkbox"/> No <i>Ask for each person with "DR Visit" in 2b:</i>			
d. How many times did -- receive this care during that period?		d.	<input style="width: 50px; height: 20px;" type="text"/> Number of times
3a. (Besides the time(s) you already told me about) During those 2 weeks, did anyone in the family get any medical advice, prescriptions or test results over the PHONE from a doctor, nurse, or anyone working with or for a medical doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No (E2)			
b. Who was the phone call about? Mark "Phone call" box in person's column.		3b.	<input type="checkbox"/> Phone call
c. Were there any calls about anyone else? <input type="checkbox"/> Yes (Reask 3b and c) <input type="checkbox"/> No <i>Ask for each person with "Phone call" in 3b:</i>			
d. How many telephone calls were made about --?		d.	<input style="width: 50px; height: 20px;" type="text"/> Number of calls
E2	<i>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.</i>		
FOOTNOTES			

F. 2-WEEK DOCTOR VISITS PAGE		DR VISIT 1
Refer to C1, "2-WK. DV" box.		PERSON NUMBER _____
F1 Refer to age.	F1 <input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)	1 a. and b. Month _____ Date _____ OR { 7777 <input type="checkbox"/> Last week 8888 <input type="checkbox"/> Week before
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 —? <i>Ask after last DR visit column for this person:</i> c. Were there any other visits or calls for — during that period? Make necessary correction to 2-Wk. DV box in C1.	1 a. and b. c. 1 <input type="checkbox"/> Yes (Reask 1a or b and c) 2 <input type="checkbox"/> No (Ask 2-6 for each visit)	2.
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? <i>If doctor's office: Was this office in a hospital?</i> <i>If hospital: Was it the outpatient clinic or the emergency room?</i> <i>If clinic: Was it a hospital outpatient clinic, a company clinic, a public health clinic, or some other kind of clinic?</i> <i>If lab: Was this lab in a hospital?</i> What was done during this visit? (Footnote)	2. 01 <input type="checkbox"/> Telephone Not in hospital: 02 <input type="checkbox"/> Home 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Co. or Ind. clinic 05 <input type="checkbox"/> Other clinic 06 <input type="checkbox"/> Lab 07 <input type="checkbox"/> Other (Specify) ▾ Hospital: 08 <input type="checkbox"/> O.P. clinic 09 <input type="checkbox"/> Emergency room 10 <input type="checkbox"/> Doctor's office 11 <input type="checkbox"/> Lab 12 <input type="checkbox"/> Overnight patient (b) 88 <input type="checkbox"/> Other (Specify) ▾	3 a. and b.
<i>Ask 3b if under 14.</i> 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? <hr/> 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?	3 a. and b. 1 <input type="checkbox"/> Yes (3f) 2 <input type="checkbox"/> No (3c) c. Type _____ 99 <input type="checkbox"/> DK d. 1 <input type="checkbox"/> One (3f) 2 <input type="checkbox"/> More 3 <input type="checkbox"/> None (4) 9 <input type="checkbox"/> DK e. and f. 1 <input type="checkbox"/> GP (4) 2 <input type="checkbox"/> Specialist (3g) 9 <input type="checkbox"/> DK (4) g. Kind of specialist _____	4 a. and b.
<i>Ask 4b if under 14.</i> 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 her pregnancy? f. What was the matter? <hr/> g. During this [visit/call] was the [doctor/(entry in 3c)] talked to about any (other) condition? h. What was the condition?	4 a. and b. 1 <input type="checkbox"/> Condition (Item C2, THEN 4g) 2 <input type="checkbox"/> Pregnancy (4e) 3 <input type="checkbox"/> Test(s) or examination (4c) 8 <input type="checkbox"/> Other (Specify) ▾ _____ (4g) c. <input type="checkbox"/> Yes (4h) <input type="checkbox"/> No d. <input type="checkbox"/> Yes (4h) <input type="checkbox"/> No (4g) e. <input type="checkbox"/> Yes <input type="checkbox"/> No (4g) f. Condition _____ (Item C2, THEN 4g) <input type="checkbox"/> Yes <input type="checkbox"/> No (5) g. <input type="checkbox"/> Yes <input type="checkbox"/> No (5) h. Condition _____ (Item C2, THEN 4g)	5 a.
<i>Mark box if "Telephone" in 2.</i> 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?	5 a. 0 <input type="checkbox"/> Telephone in 2 (Next Dr. visit) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6) b. (1) _____ (2) _____ c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No	6.
<i>Go to next DV if "Home" in 2.</i> 6. In what city (town), county, and State is the (place in 2) located?	6. City/County _____ / _____ State/ZIP Code _____ / _____	

G. HEALTH INDICATOR PAGE		
1a. During the 2-week period outlined in red on that calendar, has anyone in the family had an injury from an accident or other cause that you have not yet told me about? <input type="checkbox"/> Yes <input type="checkbox"/> No (2)		
b. Who was this? Mark "Injury" box in person's column.	1b. <input type="checkbox"/> Injury	
c. What was — injury? Enter injury(ies) in person's column.	c. _____ Injury	
d. Did anyone have any other injuries during that period? <input type="checkbox"/> Yes (Reask 1b, c, and d) <input type="checkbox"/> No		
Ask for each injury in 1c: e. As a result of the (injury in 1c) did [—/anyone] see or talk to a medical doctor or assistant (about —) or did — cut down on — usual activities for more than half of a day?		e. <input type="checkbox"/> Yes (Enter injury in C2, THEN 1e for next injury) <input type="checkbox"/> No (1e for next injury)
2. During the past 12 months, {that is, since (12-month date) a year ago} ABOUT how many days did illness or injury keep — in bed more than half of the day? (Include days while an overnight patient in a hospital.)		2. 000 <input type="checkbox"/> None _____ No. of days
3a. During the past 12 months, ABOUT how many times did [—/anyone] see or talk to a medical doctor or assistant (about —)? (Do not count doctors seen while an overnight patient in a hospital.) (Include the (number in 2-WK DV box) visit(s) you already told me about.)		3a. 000 <input type="checkbox"/> None (3b) 000 <input type="checkbox"/> Only when overnight patient in hospital } (NP) _____ No. of visits
b. About how long has it been since [—/anyone] last saw or talked to a medical doctor or assistant (about —)? Include doctors seen while a patient in a hospital.		b. 1 <input type="checkbox"/> Interview week (Reask 3b) 2 <input type="checkbox"/> Less than 1 yr. (Reask 3a) 3 <input type="checkbox"/> 1 yr., less than 2 yrs. 4 <input type="checkbox"/> 2 yrs., less than 5 yrs. 5 <input type="checkbox"/> 5 yrs. or more 0 <input type="checkbox"/> Never
4. Would you say — health in general is excellent, very good, good, fair, or poor?		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
Mark box if under 18. 5a. About how tall is — without shoes?		5a. <input type="checkbox"/> Under 18 (NP) _____ Feet _____ Inches
b. About how much does — weigh without shoes?		b. _____ Pounds
FOOTNOTES		

H. CONDITION LISTS 1 AND 2

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

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

1	<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>		2	<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>A–L are conditions affecting {Hearing Vision Speech}</p> <p>Conditions M–AA are impairments.</p>	
	<p>A. PERMANENT stiffness or any deformity of the foot, leg, fingers, arm, or back? (Permanent stiffness – joints will not move at all.)</p>			<p>A. Deafness in one or both ears?</p>	
	<p>B. Paralysis of any kind?</p>			<p>O. A missing joint?</p>	
	<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. C–L are conditions affecting the bone and muscle. M–W are conditions affecting the skin.</p>			<p>P. A missing breast, kidney, or lung?</p>	
	<p>C. Arthritis of any kind or rheumatism?</p>			<p>Q. Palsy or cerebral palsy? (ser'a-bral)</p>	
	<p>D. Gout?</p>			<p>R. Paralysis of any kind?</p>	
	<p>E. Lumbago?</p>			<p>S. Curvature of the spine?</p>	
	<p>F. Sciatica?</p>			<p>T. REPEATED trouble with neck, back, or spine?</p>	
	<p>G. A bone cyst or bone spur?</p>			<p>U. Any TROUBLE with fallen arches or flatfeet?</p>	
	<p>H. Any other disease of the bone or cartilage?</p>			<p>V. A clubfoot?</p>	
<p>I. A slipped or ruptured disc?</p>		<p>W. A trick knee?</p>			
<p>J. REPEATED trouble with neck, back, or spine?</p>		<p>X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness – joints will not move at all.)</p>			
<p>K. Bursitis?</p>		<p>Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm?</p>			
<p>L. Any disease of the muscles or tendons?</p>		<p>Z. Mental retardation?</p>			
<p>M. A tumor, cyst, or growth of the skin?</p>		<p>AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?</p>			
<p>N. Skin cancer?</p>		<p>A. A detached retina or any other condition of the retina?</p>			
<p>O. Eczema or Psoriasis? (ek'sa-ma) or (so-rye'uh-sis)</p>		<p>I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?</p>			
<p>P. TROUBLE with dry or itching skin?</p>		<p>J. A cleft palate or harelip?</p>			
<p>Q. TROUBLE with acne?</p>		<p>K. Stammering or stuttering?</p>			
<p>R. A skin ulcer?</p>		<p>L. Any other speech defect?</p>			
<p>S. Any kind of skin allergy?</p>		<p>M. Loss of taste or smell which has lasted 3 months or more?</p>			
<p>T. Dermatitis or any other skin trouble?</p>		<p>N. A missing finger, hand, or arm; toe, foot, or leg?</p>			
<p>U. TROUBLE with ingrown toenails or fingernails?</p>					
<p>V. TROUBLE with bunions, corns, or calluses?</p>					
<p>W. Any disease of the hair or scalp?</p>					

H. CONDITION LISTS 3 AND 4

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

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

3	<p>3a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 3b 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 digestive system.</p>	4	<p>4a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} have — If "Yes," ask 4b 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. 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.</p>																																																				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. Gallstones?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 3a</i></td> </tr> <tr> <td style="padding: 2px;">B. Any other gallbladder trouble?</td> <td style="padding: 2px;">N. Enteritis?</td> </tr> <tr> <td style="padding: 2px;">C. Cirrhosis of the liver?</td> <td style="padding: 2px;">O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)</td> </tr> <tr> <td style="padding: 2px;">D. Fatty liver?</td> <td style="padding: 2px;">P. Colitis?</td> </tr> <tr> <td style="padding: 2px;">E. Hepatitis?</td> <td style="padding: 2px;">Q. A spastic colon?</td> </tr> <tr> <td style="padding: 2px;">F. Yellow jaundice?</td> <td style="padding: 2px;">R. FREQUENT constipation?</td> </tr> <tr> <td style="padding: 2px;">G. Any other liver trouble?</td> <td style="padding: 2px;">S. Any other bowel trouble?</td> </tr> <tr> <td style="padding: 2px;">H. An ulcer?</td> <td style="padding: 2px;">T. Any other intestinal trouble?</td> </tr> <tr> <td style="padding: 2px;">I. A hernia or rupture?</td> <td style="padding: 2px;">U. Cancer of the stomach, intestines, colon, or rectum?</td> </tr> <tr> <td style="padding: 2px;">J. Any disease of the esophagus?</td> <td style="padding: 2px;">V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system?</td> </tr> <tr> <td style="padding: 2px;">K. Gastritis?</td> <td style="padding: 2px;"><i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i></td> </tr> <tr> <td style="padding: 2px;">L. FREQUENT indigestion?</td> <td></td> </tr> <tr> <td style="padding: 2px;">M. Any other stomach trouble?</td> <td></td> </tr> </table>	A. Gallstones?	<i>Reask 3a</i>	B. Any other gallbladder trouble?	N. Enteritis?	C. Cirrhosis of the liver?	O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)	D. Fatty liver?	P. Colitis?	E. Hepatitis?	Q. A spastic colon?	F. Yellow jaundice?	R. FREQUENT constipation?	G. Any other liver trouble?	S. Any other bowel trouble?	H. An ulcer?	T. Any other intestinal trouble?	I. A hernia or rupture?	U. Cancer of the stomach, intestines, colon, or rectum?	J. Any disease of the esophagus?	V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system?	K. Gastritis?	<i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i>	L. FREQUENT indigestion?		M. Any other stomach trouble?			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">A. A goiter or other thyroid trouble?</td> <td style="width: 50%; padding: 2px; text-align: center;"><i>Reask 4a</i></td> </tr> <tr> <td style="padding: 2px;">B. Diabetes?</td> <td style="padding: 2px;">N. Any other kidney trouble?</td> </tr> <tr> <td style="padding: 2px;">C. Anemia of any kind?</td> <td style="padding: 2px;">O. Bladder trouble?</td> </tr> <tr> <td style="padding: 2px;">D. Epilepsy?</td> <td style="padding: 2px;">P. Any disease of the genital organs?</td> </tr> <tr> <td style="padding: 2px;">E. REPEATED seizures, convulsions, or blackouts?</td> <td style="padding: 2px;">Q. A missing breast?</td> </tr> <tr> <td style="padding: 2px;">F. Multiple sclerosis?</td> <td style="padding: 2px;">R. Breast cancer?</td> </tr> <tr> <td style="padding: 2px;">G. Migraine?</td> <td style="padding: 2px;">S. *Cancer of the prostate?</td> </tr> <tr> <td style="padding: 2px;">H. FREQUENT headaches?</td> <td style="padding: 2px;">T. *Any other prostate trouble?</td> </tr> <tr> <td style="padding: 2px;">I. Neuralgia or neuritis?</td> <td style="padding: 2px;">U. **Trouble with menstruation?</td> </tr> <tr> <td style="padding: 2px;">J. Nephritis?</td> <td style="padding: 2px;">V. **A hysterectomy? If "Yes," ask: For what condition did — — have a hysterectomy?</td> </tr> <tr> <td style="padding: 2px;">K. Kidney stones?</td> <td style="padding: 2px;">W. **A tumor, cyst, or growth of the uterus or ovaries?</td> </tr> <tr> <td style="padding: 2px;">L. REPEATED kidney infections?</td> <td style="padding: 2px;">X. **Any other disease of the uterus or ovaries?</td> </tr> <tr> <td style="padding: 2px;">M. A missing kidney?</td> <td style="padding: 2px;">Y. **Any other female trouble?</td> </tr> </table>	A. A goiter or other thyroid trouble?	<i>Reask 4a</i>	B. Diabetes?	N. Any other kidney trouble?	C. Anemia of any kind?	O. Bladder trouble?	D. Epilepsy?	P. Any disease of the genital organs?	E. REPEATED seizures, convulsions, or blackouts?	Q. A missing breast?	F. Multiple sclerosis?	R. Breast cancer?	G. Migraine?	S. *Cancer of the prostate?	H. FREQUENT headaches?	T. *Any other prostate trouble?	I. Neuralgia or neuritis?	U. **Trouble with menstruation?	J. Nephritis?	V. **A hysterectomy? If "Yes," ask: For what condition did — — have a hysterectomy?	K. Kidney stones?	W. **A tumor, cyst, or growth of the uterus or ovaries?	L. REPEATED kidney infections?	X. **Any other disease of the uterus or ovaries?	M. A missing kidney?	Y. **Any other female trouble?
A. Gallstones?	<i>Reask 3a</i>																																																						
B. Any other gallbladder trouble?	N. Enteritis?																																																						
C. Cirrhosis of the liver?	O. Diverticulitis? (Dye-ver-tic-yoo-lye'tis)																																																						
D. Fatty liver?	P. Colitis?																																																						
E. Hepatitis?	Q. A spastic colon?																																																						
F. Yellow jaundice?	R. FREQUENT constipation?																																																						
G. Any other liver trouble?	S. Any other bowel trouble?																																																						
H. An ulcer?	T. Any other intestinal trouble?																																																						
I. A hernia or rupture?	U. Cancer of the stomach, intestines, colon, or rectum?																																																						
J. Any disease of the esophagus?	V. During the past 12 months, did anyone (else) in the family have any other condition of the digestive system?																																																						
K. Gastritis?	<i>If "Yes," ask: Who was this? — What was the condition? Enter in item C2, THEN reask V.</i>																																																						
L. FREQUENT indigestion?																																																							
M. Any other stomach trouble?																																																							
A. A goiter or other thyroid trouble?	<i>Reask 4a</i>																																																						
B. Diabetes?	N. Any other kidney trouble?																																																						
C. Anemia of any kind?	O. Bladder trouble?																																																						
D. Epilepsy?	P. Any disease of the genital organs?																																																						
E. REPEATED seizures, convulsions, or blackouts?	Q. A missing breast?																																																						
F. Multiple sclerosis?	R. Breast cancer?																																																						
G. Migraine?	S. *Cancer of the prostate?																																																						
H. FREQUENT headaches?	T. *Any other prostate trouble?																																																						
I. Neuralgia or neuritis?	U. **Trouble with menstruation?																																																						
J. Nephritis?	V. **A hysterectomy? If "Yes," ask: For what condition did — — have a hysterectomy?																																																						
K. Kidney stones?	W. **A tumor, cyst, or growth of the uterus or ovaries?																																																						
L. REPEATED kidney infections?	X. **Any other disease of the uterus or ovaries?																																																						
M. A missing kidney?	Y. **Any other female trouble?																																																						
			<p><i>*Ask only if males in family.</i></p> <p><i>**Ask only if females in family.</i></p>																																																				

H. CONDITION LISTS 5 AND 6

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

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

5	<p>5a. Has anyone in the family {read names} 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>	6	<p>6a. DURING THE PAST 12 MONTHS, did anyone in the family {read names} 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>																																
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J. HOSPITAL PAGE		HOSPITAL STAY 1			
<p>1. Refer to C1, "HOSP." box.</p>		1.	PERSON NUMBER _____		
<p>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])? <i>Record each entry date in a separate Hospital Stay column.</i></p>		2.	Month	Date	Year 19 _____
<p>3. How many nights was — — in the hospital?</p>		3.	0000 <input type="checkbox"/> None (Next HS) _____ Nights		
<p>4. For what condition did — — enter the hospital?</p> <ul style="list-style-type: none"> • 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 <input type="checkbox"/> Normal delivery 2 <input type="checkbox"/> Normal at birth } (5) 3 <input type="checkbox"/> No condition <input type="checkbox"/> Condition \checkmark		
<p>J1 Refer to questions 2, 3, and 2-week reference period.</p>		J1	<input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2, THEN 5) <input type="checkbox"/> No nights in 2-week reference period (5)		
<p>5a. Did — — have any kind of surgery or operation during this stay in the hospital, including bone settings and stitches?</p>		5a.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)		
<p>b. What was the name of the surgery or operation? <i>If name of operation not known, describe what was done.</i></p>		b.	(1) _____ (2) _____ (3) _____		
<p>c. Was there any other surgery or operation during this stay?</p>		c.	<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No		
<p>6. What is the name and address of this hospital?</p>		6.	Name _____ Number and street _____ City or County State		
<p>FOOTNOTES</p>					

CONDITION 1	PERSON NO. _____
1. Name of condition	
<p>Mark "2-wk. ref. pd." box without asking if "DV" or "HS" in C2 as source.</p>	
2. When did [—/anyone] last see or talk to a doctor or assistant about — (condition)?	
0 <input type="checkbox"/> Interview week (Reask 2) 1 <input type="checkbox"/> 2-wk. ref. pd. 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. 3 <input type="checkbox"/> 6 mos., less than 1 yr. 4 <input type="checkbox"/> 1 yr., less than 2 yrs.	5 <input type="checkbox"/> 2 yrs., less than 5 yrs. 6 <input type="checkbox"/> 5 yrs. or more 7 <input type="checkbox"/> Dr. seen, DK when 8 <input type="checkbox"/> DK if Dr. seen 9 <input type="checkbox"/> Dr. never seen } (3b)
3a. (Earlier you told me about — (condition)) Did the doctor or assistant call the (condition) by a more technical or specific name?	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> 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) 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy } (5)	2 <input type="checkbox"/> Cancer (3e) 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 <input type="checkbox"/> Accident/injury (Probe, then 5)	
d. Did the (condition in 3b) result from an accident or injury?	
Ask probes as necessary. Record responses in 3c: 1 <input type="checkbox"/> Yes (Probe, then 5) (How did the accident happen?) 2 <input type="checkbox"/> No (What was — doing at the time of the injury?)	
Ask 3e if the condition name in 3b includes any of the following words:	
Ailment Anemia Asthma Attack Bad	Cancer Condition Cyst Defect
Disease Disorder Growth Measles	Problem Rupture Trouble Tumor 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:

Abcess	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

Ask probes as necessary:

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

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

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

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

K1 Refer to RD and C2.
 1 "Yes" in "RD" box AND more than 1 condition in C2 (6)
 8 Other (K2)

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

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

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

Ask if "Wa/Wb" box marked in C1:
8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition?
 00 None _____ Days

Ask if age 5-17:
9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition?
 00 None _____ Days

K2
 Condition has "CL LTR" in C2 as source (10)
 Condition does not have "CL LTR" in C2 as source (K4)

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

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

K3
 Missing extremity or organ (K4)
 Other (12)

12a. Does -- still have this condition?
 1 Yes (K4) 2 No

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

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

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

K4
 0 Not an accident/injury (NC)
 1 First accident/injury for this person (14)
 8 Other (13)

13. Is this (condition in 3b) the result of the same accident you already told me about?
 Yes (Record condition page number where accident questions first completed.) → _____ (NC) Page No.
 No

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

Mark box if under 18. Under 18 (16)

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

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

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

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

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

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

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

Part(s) of body *	Kind of injury

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

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

Part(s) of body *	Present effects **

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

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)																				
1a. Did -- EVER serve on active duty in the Armed Forces of the United States?		1a. 1 <input type="checkbox"/> Yes (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.																				
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c. Was -- EVER an active member of a National Guard or military reserve unit?		c. <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)																				
d. Was ALL of -- active duty service related to National Guard or military reserve training?		d. 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK																				
2a. What is the highest grade or year of regular school -- has ever attended?		2a. 00 <input type="checkbox"/> Never attended or kindergarten (NP) Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6+																				
b. Did -- finish the (number in 2a) [grade/year]?		b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																				

FOOTNOTES

L. DEMOGRAPHIC BACKGROUND PAGE, Continued			
L2	Refer to "Age" and "Wa/Wb" boxes in C1.	L2	<input type="checkbox"/> Under 18 (NP) <input type="checkbox"/> Wa box marked (6a) <input type="checkbox"/> Wb box marked (5a) <input type="checkbox"/> Neither box marked (5b)
5a.	Earlier you said that — has a job or business but did not work last week or the week before. Was — looking for work or on layoff from a job during those 2 weeks?	5a.	1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)
b.	Earlier you said that — didn't have a job or business last week or the week before. Was — looking for work or on layoff from a job during those 2 weeks?	b.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
c.	Which, looking for work or on layoff from a job?	c.	1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)
6a.	Earlier you said that — worked last week or the week before. Ask 6b.		
b.	For whom did — work? Enter name of company, business, organization, or other employer.	6b. and c.	Employer <input type="checkbox"/> NEV (6g) <input type="checkbox"/> AF (6e)
c.	For whom did — work at — last full-time job or business lasting 2 consecutive weeks or more? Enter name of company, business, organization, or other employer, or mark "NEV" or "AF" box in person's column.		
d.	What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.	d.	Industry
If "AF" in 6b/c, mark "AF" box in person's column without asking.		e.	Occupation <input type="checkbox"/> AF (NP)
e.	What kind of work was — doing? For example, electrical engineer, stock clerk, typist, farmer.	f.	Duties
f. What were — most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.			
Complete from entries in 6b-f. If not clear, ask:		Class of worker	
g.	Was — An employee of a PRIVATE company, business or individual for wages, salary, or commission? P A FEDERAL government employee? F A STATE government employee? S A LOCAL government employee? L	g.	1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV
Self-employed in OWN business, professional practice, or farm? Ask: Is the business incorporated? Yes I No SE Working WITHOUT PAY in family business or farm? WP — NEVER WORKED or never worked at a full-time job lasting 2 weeks or more NEV			
FOOTNOTES			

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>0 <input type="checkbox"/> Under 14 1 <input type="checkbox"/> Married — spouse in HH 2 <input type="checkbox"/> Married — spouse not in HH 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Never married</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><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>1 <input type="checkbox"/> \$20,000 or more (Hand Card I) 2 <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> <hr style="border-top: 1px dashed black;"/> <p>b. Enter person number of respondent.</p>	<p>Ra.</p> <p>1 <input type="checkbox"/> Present for all questions 2 <input type="checkbox"/> Present for some questions 3 <input type="checkbox"/> Not present</p> <hr style="border-top: 1px dashed black;"/> <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>00 <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>00 <input type="checkbox"/> None in household</p>																														
<p>FOOTNOTES</p>																																

L. DEMOGRAPHIC BACKGROUND PAGE, Continued		RT 61
L5	Read to respondent: In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics.	3-4
L6	Enter date of birth from question 3 on Household Composition page.	Date of birth 5-11 Month Date Year
9a. In what State or country was -- born? Print the full name of the State or mark the appropriate box if the person was not born in the United States. ----- If born in U.S., ask 9b only; if born in foreign country, ask 9c only.		9a. 99 <input type="checkbox"/> DK (L7) 12-13 _____ State 01 <input type="checkbox"/> Puerto Rico 05 <input type="checkbox"/> Cuba 02 <input type="checkbox"/> Virgin Islands 06 <input type="checkbox"/> Mexico 03 <input type="checkbox"/> Guam 98 <input type="checkbox"/> All other countries 04 <input type="checkbox"/> Canada
b. Altogether, how many years has -- lived in (State of present residence)?		b. 1 <input type="checkbox"/> Less than 1 yr. 14 2 <input type="checkbox"/> 1 yr., less than 5 3 <input type="checkbox"/> 5 yrs., less than 10 4 <input type="checkbox"/> 10 yrs., less than 15 5 <input type="checkbox"/> 15 yrs. or more 9 <input type="checkbox"/> DK
c. Altogether, how many years has -- lived in the United States?		c. 1 <input type="checkbox"/> Less than 1 yr. 15 2 <input type="checkbox"/> 1 yr., less than 5 3 <input type="checkbox"/> 5 yrs., less than 10 4 <input type="checkbox"/> 10 yrs., less than 15 5 <input type="checkbox"/> 15 yrs. or more 9 <input type="checkbox"/> DK
L7	Print full name, including middle initial, from question 1 on Household Composition page.	Last 16-35 First 36-50 Middle initial 51
Verify for males; ask for females. 10. What is -- father's LAST name? Verify spelling. DO NOT write "Same".		Father's LAST name 52-71
Read to respondent: We also need -- Social Security Number to link with vital statistics and other records of the Department of Health and Human Services to perform health-related research. Providing this information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on -- benefits if you do provide it and this number will not be given to any other government or nongovernment agency. Read if necessary: The Public Health Service Act is title 42, United States Code, Section 242k.		99999999 <input type="checkbox"/> DK 72-80 [][] - [][] - [][][][][] Social Security Number Mark if number obtained from 81 0 <input type="checkbox"/> Does not have SSN 2 <input type="checkbox"/> Records 1 <input type="checkbox"/> Memory 7 <input type="checkbox"/> Refused
11. What is -- Social Security Number?		11.
L8	Mark box to indicate how Social Security number was or was not obtained.	1 <input type="checkbox"/> Self-personal 82 2 <input type="checkbox"/> Self-telephone 3 <input type="checkbox"/> Proxy-personal 4 <input type="checkbox"/> Proxy-telephone
L8		

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 12-16.**

12. Contact Person name Last 3-4 5-24 First 25-39 40 Middle initial RT62	14. Area code/telephone number <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> - <div style="border: 1px solid black; width: 60px; height: 20px;"></div> </div> <div style="margin-top: 5px;"> <input type="checkbox"/> None <input type="checkbox"/> Refused <input type="checkbox"/> DK </div> 97-106
13a. Address (Number and street) 41-65	107
b. City 66-85 State 86-87 ZIP Code 88-96	15. Relationship to household respondent 108-109

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

FOOTNOTES

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

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

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

FOOTNOTES