Plan and Operation of the Health and Nutrition Examination Survey

United States-1971-1973

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

Part A-Development, plan, and operation.

Part B-Data collection forms of the survey.

DHEW Publication No. (PHS) 79-1310

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Statistics
Hyattsville, Md. January 1977

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APPENDIX IIA. HANES HOUSEHOLD QUESTIONNAIRE

NOTICE – All information which would permit identification of the individual will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

O.M.B. NO. 68-R1184
APPROVAL EXPIRES DECEMBER 31, 1973

FORM HES-5 (CYCLE IV)
(10-8-71)

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

HEALTH EXAMINATION SURVEY

1. Stand No.	2. Identification code	3. PSU No.	4. Segment No.	5. Serial No.	6. Questionnaire ____ of ____ questionnaires

7. Address or description of location *(No. and St., City, State, ZIP code)*

City | State | ZIP code

Listing Sheet
Sheet No. ____
Line No. ____

8. Year built – If "Ask" box is "X"d, complete this item before the interview

☐ Ask ☐ Do not ask

When was this structure originally built?

☐ Before 4-1-60 *Continue interview* ☐ After 4-1-60 – *Go to Q. 12c, complete if required and end interview*

9. Is –– your correct mailing address? ☐ Yes ☐ No
(What is your correct mailing address?)

City | State | ZIP code

E — *If this questionnaire is for an "EXTRA" unit in "B" or NTA Segment, enter:*

Serial number of original Sample Unit	Item number by which found	Listing Sheet *(If in NTA Segment, also enter for FIRST unit listed on property)*	
		Sheet No.	Line No.

10. Type of living quarters
Mark one box → 1 ☐ Housing unit 2 ☐ Other unit

11. Special place name | Type | Type code

12. 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
☐ d. None *(item L)*

ITEM L | 2 ☐ Rural *(13)* | 1 ☐ All other *(Q. 1, p. 2)*

13. Do you own or rent this place? ☐ Own ☐ Rent ☐ Rent free

14a. How many acres of land are included? 1 ☐ 10 or more acres *(b)* 2 ☐ Less than 10 acres *(c)*

b. During the past 12 months did sales of crops, livestock, and other farm products from the place amount to $50 or more? 2 ☐ Yes *(Q. 1, p. 2)* 4 ☐ No *(Q. 1, p. 2)*

c. During the past 12 months did sales of crops, livestock, and other farm products from the place amount to $250 or more? 3 ☐ Yes *(Q. 1, p. 2)* 5 ☐ No *(Q. 1, p. 2)*

15. What is the telephone number here?
☐ None

16. INTERVIEWER
(Ask only for households with EP's)
The information you have just given me will be used by the Public Health Service to determine which persons will be asked to participate in the other part of this survey. That part will cover health and nutrition. If anyone in your household is selected, a representative of the U.S. Public Health Service will be calling on you within a week or so to explain the second part. What would be the best time for her to visit you –– morning or afternoon?

Day | Time a.m. p.m.

Name of respondent

LEAVE THANK YOU LETTER

17. RECORD OF CALLS AT HOUSEHOLD

	1	Com.	2	Com.	3	Com.	4	Com.	5	Com.	6	Com.
Date												
Time	a.m. p.m.		a.m. p.m.		a.m. p.m.		a.m. p.m.		a.m. p.m.		a.m. p.m.	

18. REASON FOR NONINTERVIEW

TYPE A
(Complete items 1-14, 17-20)
☐ Refusal – *Describe in footnotes*
☐ No one at home – repeated calls
☐ Temporarily absent
☐ Other – *Specify*
Go to 19a

TYPE B
(Complete items 1-12, L, 14, 17, 18, and 20)
☐ Vacant – non-seasonal
☐ Vacant – seasonal
☐ Usual residence elsewhere
☐ Armed Forces
☐ Other – *Specify*

TYPE C
(Complete items 1-8, 11, 17, 18, and 20)
☐ Demolished
☐ In sample by mistake
☐ Eliminated in sub-sample
☐ Built after April 1, 1960
☐ Other – *Specify*

TYPE Z
(Partial interview)
Interview not obtained for:
Person No. ___ ___ ___ ___
because:

19a. For "final" Type A noninterviews enter names, approximate ages, and sex of household members.

	Name	Age	Sex		Name	Age	Sex
1.				4.			
2.				5.			
3.				6.			

19b. Who supplied this information?
Name
Number and street, route, or box number
City

19c. Race
☐ W ☐ N ☐ OT

20. Signature of interviewer | Code

Footnotes

WASHINGTON USE ONLY	
Total number of persons	Total number of sample persons

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

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

TABLE X – LIVING QUARTERS DETERMINATIONS AT LISTED ADDRESS

Line No.	LOCATION OF UNIT		B SEGMENTS ONLY		USE OR CHARACTERISTICS			CLASSIFICATION	IF HU IN B SEGMENT ASK:	
	Where are these quarters located? *(Enter exact description or location, e.g., basement; 2nd floor, rear)* *(If outside Area Segment boundary, specify in notes; STOP Table X and continue with item 12 OR L)*	If listed, enter sheet and line number and stop. If unlisted and: – B Segment – *Go to Col. 4* – Area Segment – *Go to Col. 5*	INTERVIEWER: Are these quarters within the specific sample address shown in columns 2–4 of the B Segment List? *(If "Yes," continue Table X. If "No," STOP Table X and continue with item 12 OR L)*	Are these *(specify location)* quarters for more than one group of people? *(If "Yes," fill one line for each group)*	OCCUPIED: Do the occupants of these *(specify location)* quarters live and eat with any other group of people?	ALL QUARTERS: Do these quarters in *(specify location)* have: Direct access from the outside or through a common hall?	ALL QUARTERS: A kitchen or cooking equipment for exclusive use?	N – Not a separate unit, add occupants to this questionnaire. *(Complete a separate questionnaire for each unrelated person or family group.)* HU, Ot – Separate unit. Interview on a separate questionnaire.	In what year were these quarters *(specify location)* created? *(If 1959 or 1960, specify "F" if first half, or "L" if last half.)*	*(If before July 1960)* What was the name of the household head of these quarters on April 1, 1960?
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
1		S__ L__	Y N	Y N	Y *(9)* N	Y N	Y N	N HU Ot		
2		S__ L__	Y N	Y N	Y *(9)* N	Y N	Y N	N HU Ot		
3		S__ L__	Y N	Y N	Y *(9)* N	Y N	Y N	N HU Ot		

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

APPENDIX IIB. FOOD PROGRAMS QUESTIONNAIRE

HSM-411-11 (PAGE 1)
REV. 8/71

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

FOOD PROGRAMS QUESTIONNAIRE

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

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

a. Name of respondent (*Last, first, middle*)	b. Deck No.	c. Segment No.	d. Serial No.	e. Column No.
	101	_ _ _ _ _ _	_ _	_ _

FOR INTERVIEWER USE ONLY

Mark appropriate box before going into household.

(001)
Not applicable
1 ☐ Items 1 and 2 not applicable by HES income and family size criteria – *SKIP to 3a*
Applicable
2 ☐ No program available – *SKIP to 3a*
3 ☐ Food stamps available – *Ask 1a*
4 ☐ Commodities available – *SKIP to 2a*

1a. Are you certified to participate in the food stamp program?
1a. (002) 1 ☐ Yes – *Ask b*
2 ☐ No } *SKIP to 3a*
9 ☐ Don't know } *SKIP to 3a*

b. Are you buying food stamps now?
b. (003) 1 ☐ Yes, regularly } *SKIP to 3a*
2 ☐ Yes, occasionally } *SKIP to 3a*
3 ☐ No – *Ask c*

c. What is the MAIN reason you aren't participating in the program?
c. (004) 1 ☐ No need
2 ☐ Not enough money at the time
3 ☐ No transportation
4 ☐ Pride
5 ☐ Other – *Specify* ____________

2a. Are you certified to participate in the commodity distribution program?
2a. (005) 1 ☐ Yes – *Ask b*
2 ☐ No } *SKIP to 3a*
9 ☐ Don't know } *SKIP to 3a*

b. Are you receiving commodity foods now for your family?
b. (006) 1 ☐ Yes, regularly } *SKIP to 3a*
2 ☐ Yes, occasionally } *SKIP to 3a*
3 ☐ No – *Ask c*

c. Why aren't you participating in the program?
c. (007) 1 ☐ No need
2 ☐ No transportation
3 ☐ Pride
4 ☐ Other – *Specify* ____________

Ask the following questions only in households where there are sample children or youths attending school.	First name	*BEGIN NEW RECORD*	Deck No.	Sample No.
			102	_ _ _ _ _

3a. Is there a school lunch program at the school that . . . attends?
3a. (001) 1 ☐ Yes – *Ask b*
2 ☐ No } *SKIP to d*
9 ☐ Don't know } *SKIP to d*

b. How many times a week does he usually participate?
b. (002) __ Times

c. How much does he pay for his lunch per day?
c. (003) _ _ Cents

d. Is there a special milk program at the school that . . . attends?
d. (004) 1 ☐ Yes – *Ask e*
2 ☐ No } *SKIP to f*
9 ☐ Don't know } *SKIP to f*

e. How many times a week does he usually participate?
e. (005) __ Times

f. Is there a school breakfast program at the school that . . . attends?
f. (006) 1 ☐ Yes – *Ask g and h*
2 ☐ No } *Go to next sample child*
9 ☐ Don't know } *Go to next sample child*

g. How many times a week does he usually participate?
g. (007) __ Times

h. How much does he pay for his breakfast per day?
h. (008) _ _ Cents

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

APPENDIX IIC. MEDICAL HISTORY QUESTIONNAIRE, AGES 1-5

HSM-411-8 (PAGE 1)

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

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

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

MEDICAL HISTORY QUESTIONNAIRE – AGES 1–5

a. Child's name (*Last, first, middle*)	b. Deck No. 061	c. Sample No. _ _ _ _ _	d. Segment No. _ _ _ _ _ _

e. Serial No. _ _	f. Column No. _ _	g. Sex 1 ☐ Male 2 ☐ Female	h. Age 0_	i. Date of birth Month _ _ Day _ _ Year _ _

1. How much did . . . weigh when he was born? — (001) _ _ Pounds _ _ Ounces; 9999 ☐ Don't know

2. Was . . . born prematurely? (that is, early or not carried the full nine months) — (002) 1 ☐ Yes; 2 ☐ No; 9 ☐ Don't know

3. How old was . . . 's mother when . . . was born? — (003) _ _ Years old; 99 ☐ Don't know

4a. How many children has . . . 's mother had? — (004) _ _ Children – *If more than 1, Ask b*; 99 ☐ Don't know – *SKIP to 5*

b. How many were born before . . . ? — (005) _ _ Children; 99 ☐ Don't know

5. How many of . . . 's brothers and sisters weighed less than five and one half pounds at birth? — (006) _ _ Brothers and sisters; 99 ☐ Don't know

6. How much did . . . weigh when he was a year old? — (007) _ _ Pounds; 99 ☐ Don't know

7. How much did . . . weigh when he was two years old? — (008) _ _ Pounds; 88 ☐ Not yet two; 99 ☐ Don't know

8. How old was . . . when he got his first tooth? — (009) _ _ Months; 99 ☐ Don't know

9. How old was . . . when he first sat up by himself? — (010) _ _ Months; 88 ☐ Doesn't sit up yet; 99 ☐ Don't know

10. How old was . . . when he first walked by himself? — (011) _ _ Months; 88 ☐ Doesn't walk yet; 99 ☐ Don't know

11a. Was . . . breast fed at any time? — (012) 1 ☐ Yes – *Ask b*; 2 ☐ No, 9 ☐ Don't know } *SKIP to 12a*

b. How old was he when he stopped breast feeding? — (013) _ _ Months; 88 ☐ Still breast fed; 99 ☐ Don't know

12a. As a baby, was . . . at any time fed milk from a bottle? — (014) 1 ☐ Yes – *Ask b*; 2 ☐ No, 9 ☐ Don't know } *SKIP to 13*

b. What type of milk was used?

		Yes	No	Don't know
(1) Whole cow's milk	(015)	1 ☐	2 ☐	9 ☐
(2) Commercially prepared milk – *Specify brand if known* ____	(016)	1 ☐	2 ☐	9 ☐
(3) A soy base formula	(017)	1 ☐	2 ☐	9 ☐
(4) Other – *Specify* ____	(018)	1 ☐	2 ☐	9 ☐

13. How old was . . . when he first started eating solid foods like cereal or fruit? *INTERVIEWER – Convert replies in weeks to nearest whole number of months* — (019) _ _ Months; 99 ☐ Don't know

14. Has . . . had the following immunizations?

		Yes	No	Don't know
DPT (Diphtheria, whooping cough, and tetanus)	(020)	1 ☐	2 ☐	9 ☐
Polio	(021)	1 ☐	2 ☐	9 ☐
Smallpox	(022)	1 ☐	2 ☐	9 ☐
Measles	(023)	1 ☐	2 ☐	9 ☐
German Measles	(024)	1 ☐	2 ☐	9 ☐
Mumps	(025)	1 ☐	2 ☐	9 ☐
Other, don't know what for	(026)	1 ☐	2 ☐	9 ☐

15. Does or did . . . have any conditions he was born with that involved any of the following?

		Yes	No	Don't know
Heart	(027)	1 ☐	2 ☐	9 ☐
Eyes	(028)	1 ☐	2 ☐	9 ☐
Mouth or throat	(029)	1 ☐	2 ☐	9 ☐
Stomach or intestines	(030)	1 ☐	2 ☐	9 ☐
Kidneys or urinary system	(031)	1 ☐	2 ☐	9 ☐
Muscles, bones, or joints	(032)	1 ☐	2 ☐	9 ☐
Brain or nervous system	(033)	1 ☐	2 ☐	9 ☐

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

APPENDIX IID. MEDICAL HISTORY QUESTIONNAIRE, AGES 6-11

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REV. 8/71

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

MEDICAL HISTORY QUESTIONNAIRE – AGES 6–11

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

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

a. Name (Last, first, middle)	b. Deck No. 071	c. Sample No. _ _ _ _ _	d. Segment No. _ _ _ _ _ _

e. Serial No.	f. Column No.	g. Sex	h. Age	i. Date of birth Month	Day	Year
_ _	_ _	1 ☐ Male 2 ☐ Female	_ _	_ _	_ _	_ _

1. How much did . . . weigh when he was born?
(001) _ _ Pounds _ _ Ounces
9999 ☐ Don't know

2. Was . . . born prematurely? (That is, early or not carried the full nine months)
(002) 1 ☐ Yes
2 ☐ No
9 ☐ Don't know

3a. How many children has . . .'s mother had?
(003) _ _ Children – *If more than 1, Ask b*
99 ☐ Don't know – *SKIP to 4*

b. How many were born before . . .?
(004) _ _ Children
99 ☐ Don't know

4. How many of . . .'s brothers and sisters weighed less than five and one-half pounds at birth?
(005) _ _ Brothers and sisters
99 ☐ Don't know

5. How much did . . . weigh when he was a year old?
(006) _ _ Pounds
99 ☐ Don't know

6a. Was . . . breast fed at any time?
(007) 1 ☐ Yes – *Ask b*
2 ☐ No } *SKIP to 7a*
9 ☐ Don't know } *SKIP to 7a*

b. How old was . . . when he stopped breast feeding?
(008) _ _ Months
99 ☐ Don't know

7a. As a baby, was . . . at any time fed milk from a bottle?
(009) 1 ☐ Yes – *Ask 7b*
2 ☐ No } *SKIP to 8*
9 ☐ Don't know } *SKIP to 8*

b. What type of milk was used?

		Yes	No	Don't know
(1) Whole cow's milk	(010)	1 ☐	2 ☐	9 ☐
(2) Commercially prepared milk – *Specify brand if known* _____	(011)	1 ☐	2 ☐	9 ☐
(3) A soy base formula	(012)	1 ☐	2 ☐	9 ☐
(4) Other – *Specify* _____	(013)	1 ☐	2 ☐	9 ☐

8. How old was . . . when he first started eating solid foods like cereal or fruit? *INTERVIEWER: convert replies in weeks to nearest number of months.*
(014) _ _ Months
99 ☐ Don't know

9. Does or did . . . have any conditions he was born with that involved any of the following?

		Yes	No	Don't know
Heart	(015)	1 ☐	2 ☐	9 ☐
Eyes	(016)	1 ☐	2 ☐	9 ☐
Mouth or throat	(017)	1 ☐	2 ☐	9 ☐
Stomach or intestines	(018)	1 ☐	2 ☐	9 ☐
Kidneys or urinary system	(019)	1 ☐	2 ☐	9 ☐
Muscles, bones, or joints	(020)	1 ☐	2 ☐	9 ☐
Brain or nervous system	(021)	1 ☐	2 ☐	9 ☐

Question		Item	Response		
10. Has . . . ever been treated for the following?	10.		Yes	No	Don't know
Anemia		(022)	1 ☐	2 ☐	9 ☐
Abnormal bleeding		(023)	1 ☐	2 ☐	9 ☐
Asthma		(024)	1 ☐	2 ☐	9 ☐
Other allergies		(025)	1 ☐	2 ☐	9 ☐
Tuberculosis		(026)	1 ☐	2 ☐	9 ☐
Pneumonia		(027)	1 ☐	2 ☐	9 ☐
Other chest or lung condition		(028)	1 ☐	2 ☐	9 ☐
Heart condition		(029)	1 ☐	2 ☐	9 ☐
Diabetes		(030)	1 ☐	2 ☐	9 ☐
Epilepsy or convulsions		(031)	1 ☐	2 ☐	9 ☐
Stomach or intestinal disorder (excluding diarrhea)		(032)	1 ☐	2 ☐	9 ☐
Kidney disease or infection		(033)	1 ☐	2 ☐	9 ☐
Thyroid disease or goiter		(034)	1 ☐	2 ☐	9 ☐
Cancer or tumors		(035)	1 ☐	2 ☐	9 ☐
Other conditions – *Specify* ________		(036)	1 ☐	2 ☐	9 ☐

11a. Has . . . ever had a bad accident? — 11a. (037)
1 ☐ Yes – *Ask b*
2 ☐ No
9 ☐ Don't know } *SKIP to 12a*

b. Does he still have the effects of it? — b. (038)
1 ☐ Yes – *Ask c*
2 ☐ No – *SKIP to 12a*

c. What are they? ________

12a. Has . . . ever stayed overnight in a hospital? — 12a. (039)
1 ☐ Yes – *Ask b and c*
2 ☐ No – *SKIP to 13a*

b. For what? ________

c. Has . . . ever had an operation? — c. (040)
1 ☐ Yes – *Ask d*
2 ☐ No – *SKIP to 13a*

d. For what? ________

13a. Is . . . unable to do some things because of a condition that has bothered him for a long time? — 13a. (041)
1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 14a*

b. What can't he do? ________

14a. During the past six months how many colds has . . . had? — 14a. (042)
____ Colds

b. Does he have one now? — b. (043)
1 ☐ Yes
2 ☐ No

15a. During the past six months has . . . passed any worms? — 15a. (044)
1 ☐ Yes – *Ask b*
2 ☐ No
9 ☐ Don't know } *SKIP to 16a*

b. What type, tiny white or pencil-sized? — b. (045)
1 ☐ Tiny white
2 ☐ Pencil-sized
3 ☐ Both

16a. During the past six months how many times has . . . had diarrhea? — 16a. (046)
_ _ Times

b. Does he have it now? — b. (047)
1 ☐ Yes
2 ☐ No

17a. Does . . . ever eat dirt or clay, starch, paint or plaster, or any material that might be considered unusual? — 17a. (048)
1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP TO 18*

b. Which?	b.	Item	Yes	No
Dirt or clay		(049)	1 ☐	2 ☐
Starch		(050)	1 ☐	2 ☐
Paint or plaster		(051)	1 ☐	2 ☐
Other – *Specify* ________		(052)	1 ☐	2 ☐

Question		Code	Response
18. Does . . . have unusual trouble seeing at night or in the dark?	18.	053	1 ☐ Yes 2 ☐ No 9 ☐ Don't know
19a. Has . . . ever had any other trouble seeing?	19a.	054	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 20a*
b. Was it because of either an eye injury, infection or other eye problem? (1) An eye injury	b.	055	1 ☐ Yes 2 ☐ No
(2) An eye infection or other eye problem		056	1 ☐ Yes 2 ☐ No – *If "No" to both (1) and (2) SKIP to 20a*
c. Did he see a doctor about it? (1) An eye injury	c.	057	1 ☐ Yes 2 ☐ No
(2) An eye infection or other eye problem		058	1 ☐ Yes – *Ask d* 2 ☐ No – *If "No" to both (1) and (2) SKIP to 20a*
d. What did he say the trouble was? ______			
20a. Has . . . ever had an eye accident or eye injury that did not affect his vision?	20a.	059	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 21a*
b. Did he see a doctor about it?	b.	060	1 ☐ Yes 2 ☐ No
21a. Has . . . ever worn glasses or contact lenses?	21a.	061	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 22*
b. Does he still wear them?	b.	062	1 ☐ Yes 2 ☐ No
c. When does (did) he wear them?	c.		Yes / No
All the time		063	1 ☐ / 2 ☐
For reading or close work		064	1 ☐ / 2 ☐
For distance vision		065	1 ☐ / 2 ☐
At other times – *Specify* ______		066	1 ☐ / 2 ☐
d. Does (did) he have trouble with his vision even when wearing glasses (or contact lenses)?	d.	067	1 ☐ Yes 2 ☐ No
e. How old was he when he first wore glasses (or contact lenses)?	e.	068	— — Years
22. Has . . . ever had to miss school because of trouble seeing or other trouble with his eyes?	22.	069	1 ☐ Yes 2 ☐ No
Here are some questions about . . .'s mother: 23a. How much does she weigh?	23a.	070	— — — Pounds 999 ☐ Don't know
b. How tall is she?	b.	071	— — Feet — — Inches 999 ☐ Don't know
Here are some questions about . . .'s father: 24a. How much does he weigh?	24a.	072	— — — Pounds 999 ☐ Don't know
b. How tall is he?	b.	073	— — Feet — — Inches 999 ☐ Don't know
25a. Do you use iodized table salt?	25a.	074	1 ☐ Yes } *Skip to 26a* 2 ☐ No } 9 ☐ Don't know – *Ask b*
b. May I see your box of table salt?	b.	075	1 ☐ Iodized 2 ☐ Not iodized 3 ☐ No box
26a. Name of respondent ______			
b. Respondent's relationship to child covered by this questionnaire	b.	076	1 ☐ Mother 2 ☐ Other

NOTES

HSM-411-10 (PAGE 1)
REV. 8/71

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

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

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

MEDICAL HISTORY QUESTIONNAIRE – AGES 12–74

a. Name (*Last, first, middle*)	b. Deck No.	c. Sample No.	d. Segment No.
	081	______	______

e. Serial No.	f. Column No.	g. Sex	h. Age	i. Date of Birth: Month	Day	Year
__	__	1 ☐ Male 2 ☐ Female	__	__	__	__

1a. Do you have an illness or condition which interferes with your eating?
(001) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 2a*

b. What? ____________________

2a. Do you have an illness which has recently cut down your appetite?
(002) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 3a*

b. What? ____________________

3a. Do you have trouble chewing steaks, chops, or other firm meats?
(003) 1 ☐ Yes
2 ☐ No

b. Do you have trouble biting apples or corn-on-the-cob?
(004) 1 ☐ Yes
2 ☐ No

c. Do you have trouble biting or chewing any other food?
(005) 1 ☐ Yes
2 ☐ No

4a. Are there any foods which you avoid eating because they disagree with you?
(006) 1 ☐ Yes – Ask b
2 ☐ No – *SKIP to 5*

b. What are they?

		Yes	No
Milk	(007)	1 ☐	2 ☐
Fats	(008)	1 ☐	2 ☐
Greens	(009)	1 ☐	2 ☐
Seafood	(010)	1 ☐	2 ☐
Other – *Specify* ______	(011)	1 ☐	2 ☐

5. Do you have episodes (or "spells") of pain or discomfort in your abdomen or stomach of at least 3 days per month? (Don't count ones that go with a cold, sore throat, flu or (for women) menstrual periods.)
(012) 1 ☐ Yes
2 ☐ No

6. Do you have difficulty in swallowing at least 3 days per month? (Don't count the difficulty in swallowing that goes with a cold, sore throat or flu.)
(013) 1 ☐ Yes
2 ☐ No

7. Do you have episodes (or "spells") of vomiting of at least 3 days per month? (Don't count ones that go with colds, sore throats, flu, or (for women) menstrual periods.)
(014) 1 ☐ Yes
2 ☐ No

8. Have you ever had yellow jaundice, which made your skin or eyes turn yellow?
(015) 1 ☐ Yes
2 ☐ No

9a. Did a doctor ever tell you that you had protein, albumin, blood or sugar in your urine?
(016) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 10*

b. Which?

		Yes	No
Protein	(017)	1 ☐	2 ☐
Albumin	(018)	1 ☐	2 ☐
Blood	(019)	1 ☐	2 ☐
Sugar	(020)	1 ☐	2 ☐

10. During the past six months have you had parasites or worms in your stools?
(021) 1 ☐ Yes
2 ☐ No
3 ☐ Don't know

11a. Do you have trouble with your bowels which makes you constipated or gives you diarrhea?
(022) 1 ☐ Yes – constipated
2 ☐ Yes – diarrhea
3 ☐ No

b. How often do you usually have a bowel movement?
(023) 1 ☐ Once a week or less often
2 ☐ 2 – 3 times a week
3 ☐ 4 – 6 times a week
4 ☐ Once a day
5 ☐ 2 – 3 times a day
6 ☐ 4 or more times a day

c. Have your movements ever been white, gray, dark black, or streaked with blood?
(024) 1 ☐ Yes – *Ask d*
2 ☐ No – *SKIP to 12a*

d. Which?

		Yes	No
White	(025)	1 ☐	2 ☐
Gray	(026)	1 ☐	2 ☐
Dark black	(027)	1 ☐	2 ☐
Streaked with blood	(028)	1 ☐	2 ☐

12a. Have you had an abdominal operation?	12a. (030)	1 ☐ Yes – *Ask 12b* 2 ☐ No – *SKIP to 13a*

b. What for?		Yes	No
Ulcers	(031)	1 ☐	2 ☐
Gallstones	(032)	1 ☐	2 ☐
Hiatus hernia of the diaphragm	(033)	1 ☐	2 ☐
Tumor of the stomach, bowel, or colon	(034)	1 ☐	2 ☐
Tumor or cyst of the womb or ovaries	(035)	1 ☐	2 ☐
Other – *Specify* ________	(036)	1 ☐	2 ☐

13a. Has a doctor ever told you that you had any of the following conditions? *If "Yes" to any of the following conditions, ask 13b and 13c for those conditions.*	13a. No	**13b. Do you still have it?** Yes	No	Don't know	**13c. How many years ago did you first have it?**
Arthritis	(037) 2 ☐	1 ☐	3 ☐	9 ☐	(038) __ __
Gout	(039) 2 ☐	1 ☐	3 ☐	9 ☐	(040) __ __
Asthma	(041) 2 ☐	1 ☐	3 ☐	9 ☐	(042) __ __
Chronic bronchitis or emphysema	(043) 2 ☐	1 ☐	3 ☐	9 ☐	(044) __ __
Tuberculosis	(045) 2 ☐	1 ☐	3 ☐	9 ☐	(046) __ __
Rheumatic fever	(047) 2 ☐	1 ☐	3 ☐	9 ☐	(048) __ __
Heart murmur	(049) 2 ☐	1 ☐	3 ☐	9 ☐	(050) __ __
Heart failure	(051) 2 ☐	1 ☐	3 ☐	9 ☐	(052) __ __
Heart attack	(053) 2 ☐	1 ☐	3 ☐	9 ☐	(054) __ __
High blood pressure	(055) 2 ☐	1 ☐	3 ☐	9 ☐	(056) __ __
Stroke	(057) 2 ☐	1 ☐	3 ☐	9 ☐	(058) __ __
Ulcers (peptic, stomach, duodenal)	(059) 2 ☐	1 ☐	3 ☐	9 ☐	(060) __ __
Enteritis (recurrent or chronic)	(061) 2 ☐	1 ☐	3 ☐	9 ☐	(062) __ __
Colitis (spastic colon, mucous colitis)	(063) 2 ☐	1 ☐	3 ☐	9 ☐	(064) __ __
Gallstones	(065) 2 ☐	1 ☐	3 ☐	9 ☐	(066) __ __
Hepatitis	(067) 2 ☐	1 ☐	3 ☐	9 ☐	(068) __ __
Chronic cough	(069) 2 ☐	1 ☐	3 ☐	9 ☐	(070) __ __
Pleurisy	(071) 2 ☐	1 ☐	3 ☐	9 ☐	(072) __ __
Low blood pressure	(073) 2 ☐	1 ☐	3 ☐	9 ☐	(074) __ __
Hives	(075) 2 ☐	1 ☐	3 ☐	9 ☐	(076) __ __
Hay fever	(077) 2 ☐	1 ☐	3 ☐	9 ☐	(078) __ __
Allergies to foods	(079) 2 ☐	1 ☐	3 ☐	9 ☐	(080) __ __
Other allergies	(081) 2 ☐	1 ☐	3 ☐	9 ☐	(082) __ __
Thyroid disease	(083) 2 ☐	1 ☐	3 ☐	9 ☐	(084) __ __
Diabetes	(085) 2 ☐	1 ☐	3 ☐	9 ☐	(086) __ __
Polio or paralysis	(087) 2 ☐	1 ☐	3 ☐	9 ☐	(088) __ __
Hiatus hernia (of the diaphragm)	(089) 2 ☐	1 ☐	3 ☐	9 ☐	(090) __ __
Loss of blood from stomach or bowels	(091) 2 ☐	1 ☐	3 ☐	9 ☐	(092) __ __
Kidney disease or kidney stones	(093) 2 ☐	1 ☐	3 ☐	9 ☐	(094) __ __
Malignant tumor or growth	(095) 2 ☐	1 ☐	3 ☐	9 ☐	(096) __ __
Benign tumor, growth, or cyst (except fat or skin)	(097) 2 ☐	1 ☐	3 ☐	9 ☐	(098) __ __
Trouble with blood not clotting properly	(099) 2 ☐	1 ☐	3 ☐	9 ☐	(100) __ __
Nervous breakdown	(101) 2 ☐	1 ☐	3 ☐	9 ☐	(102) __ __
Fracture of hip	(103) 2 ☐	1 ☐	3 ☐	9 ☐	(104) __ __
Fracture of wrist	(105) 2 ☐	1 ☐	3 ☐	9 ☐	(106) __ __
Fracture of spine	(107) 2 ☐	1 ☐	3 ☐	9 ☐	(108) __ __

14a. Have you ever had anemia, sometimes called "low blood"?	14a. (109)	1 ☐ Yes – *Ask b* 2 ☐ No 9 ☐ Don't know } *SKIP to 15a*
b. How long ago?	b. (110)	__ __ Years 99 ☐ Don't remember
c. Did a doctor tell you that you had anemia?	c. (111)	1 ☐ Yes – *Ask d* 2 ☐ No – *SKIP to e*

d. What caused it?	d.	Yes	No	Don't know
Poor diet	(112)	1 ☐	2 ☐	9 ☐
Childbirth	(113)	1 ☐	2 ☐	9 ☐
Accidental loss of blood	(114)	1 ☐	2 ☐	9 ☐
Illness	(115)	1 ☐	2 ☐	9 ☐
Surgery	(116)	1 ☐	2 ☐	9 ☐
Other – *Specify* ________	(117)	1 ☐	2 ☐	9 ☐

e. Were you treated for this condition by a doctor?	e. (118)	1 ☐ Yes – *Ask f* 2 ☐ No – *SKIP to 15a*

f. How?	f.	Yes	No
Better diet	(119)	1 ☐	2 ☐
Iron pills	(120)	1 ☐	2 ☐
Iron shots	(121)	1 ☐	2 ☐
Vitamin pills	(122)	1 ☐	2 ☐
Vitamin shots	(123)	1 ☐	2 ☐
Transfusions	(124)	1 ☐	2 ☐
Other – *Specify* ________	(125)	1 ☐	2 ☐

g. Are you still being treated for it?	g. (126)	1 ☐ Yes 2 ☐ No

15a. Have you EVER had trouble seeing? — 15a. (127) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 16a*

b. Did you see a doctor about it? — b. (128) 1 ☐ Yes – *Ask c* 2 ☐ No – *SKIP to 16a*

c. What did he say the trouble was? ______________________

16a. Have you ever worn glasses or contact lenses? — 16a. (129) 1 ☐ Yes, glasses 2 ☐ Yes, contact lenses 3 ☐ Yes, contacts and glasses } *Ask b* 4 ☐ No – *SKIP to 17*

b. Do you still wear them? — b. (130) 1 ☐ Yes 2 ☐ No

c. When do (did) you wear them? — c.

		Yes	No
All the time	(131)	1 ☐	2 ☐
For reading or close work	(132)	1 ☐	2 ☐
For distance vision	(133)	1 ☐	2 ☐
At other times – *Specify* ______	(134)	1 ☐	2 ☐

d. Do (did) you have trouble with your vision even when wearing glasses or contact lenses? — d. (135) 1 ☐ Yes, with glasses 2 ☐ Yes, with contacts 3 ☐ Yes, with both 4 ☐ No

e. How old were you when you first wore glasses or contact lenses, whichever one was first in case you have worn both? — e. (136) 1 ☐ 0 – 4 years old 2 ☐ 5 – 9 years old 3 ☐ 10 – 19 years old 4 ☐ 20 – 29 years old 5 ☐ 30 – 39 years old 6 ☐ 40 – 49 years old 7 ☐ 50 years old or older

17. Have you ever had to miss work or school because of trouble seeing or other trouble with your eyes? — 17. (137) 1 ☐ Yes 2 ☐ No

18a. During the past year, have you had at least one drink of beer, wine, or liquor? — 18a. (138) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 19a*

b. How often do you drink? — b. (139) 1 ☐ Every day 2 ☐ Just about every day 3 ☐ About 2 or 3 times a week 4 ☐ About 1 – 4 times a month 5 ☐ More than 3 but less than 12 times a year 6 ☐ No more than 2 or 3 times a year – *SKIP to 19a*

c. Which do you most frequently drink - - beer, wine, or liquor? — c. (140) 1 ☐ Beer 2 ☐ Wine 3 ☐ Liquor

d. When you drink (beer/wine/liquor) how much do you usually drink over 24 hours? *(Enter an amount only for the one marked in 18c.)* — d. (141) _ _ Glasses of beer _ _ Glasses of wine _ _ Drinks of liquor

19a. Do you eat dirt or clay, starch, or any materials which might be considered unusual? — 19a. (142) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 20*

b. Which?

		Yes	No
Dirt or clay	(143)	1 ☐	2 ☐
Starch	(144)	1 ☐	2 ☐
Other – *Specify* ______	(145)	1 ☐	2 ☐

20. During the past six months, have you used any medicine, drugs, or pills for any of the following? — 20.

		Regularly	Occasionally	No
Sleep problems or insomnia	(146)	1 ☐	2 ☐	3 ☐
Headache	(147)	1 ☐	2 ☐	3 ☐
Other pains	(148)	1 ☐	2 ☐	3 ☐
Upset stomach or indigestion	(149)	1 ☐	2 ☐	3 ☐
Weak heart	(150)	1 ☐	2 ☐	3 ☐
Allergies	(151)	1 ☐	2 ☐	3 ☐
Nerves	(152)	1 ☐	2 ☐	3 ☐
Thyroid trouble	(153)	1 ☐	2 ☐	3 ☐
Lack of pep (except thyroid pills)	(154)	1 ☐	2 ☐	3 ☐
Convulsions	(155)	1 ☐	2 ☐	3 ☐
High blood pressure	(156)	1 ☐	2 ☐	3 ☐
Bowel trouble	(157)	1 ☐	2 ☐	3 ☐
Skin conditions	(158)	1 ☐	2 ☐	3 ☐
Water loss (fluid pills)	(159)	1 ☐	2 ☐	3 ☐
Weight loss (except fluid pills)	(160)	1 ☐	2 ☐	3 ☐
Infection (antibiotic or sulfa pills or shots only)	(161)	1 ☐	2 ☐	3 ☐

21a. Are you on a special diet? 21a.	(162) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 22*
b. What is it for? b.	Yes / No
To lose weight	(163) 1 ☐ 2 ☐
Diabetes	(164) 1 ☐ 2 ☐
Kidney failure	(165) 1 ☐ 2 ☐
Ulcers	(166) 1 ☐ 2 ☐
Allergies	(167) 1 ☐ 2 ☐
Heart trouble or high blood pressure	(168) 1 ☐ 2 ☐
Pregnancy	(169) 1 ☐ 2 ☐
Other – *Specify* ______	(170) 1 ☐ 2 ☐
c. What kind of diet is this? c.	Yes / No
Low fat	(171) 1 ☐ 2 ☐
Low protein	(172) 1 ☐ 2 ☐
Low salt	(173) 1 ☐ 2 ☐
Low carbohydrate	(174) 1 ☐ 2 ☐
Low calorie	(175) 1 ☐ 2 ☐
Other – *Specify* ______	(176) 1 ☐ 2 ☐
d. Was this diet ordered by a doctor? d.	(177) 1 ☐ Yes 2 ☐ No
22. Do you get much exercise in things you do for recreation (sports, or hiking, or anything like that), or hardly any exercise, or in between? 22.	(178) 1 ☐ Much exercise 2 ☐ Moderate exercise 3 ☐ Little or no exercise
23. In your usual day, aside from recreation, are you physically very active, moderately active, or quite inactive? 23.	(179) 1 ☐ Very active 2 ☐ Moderately active 3 ☐ Quite inactive
24a. Do you use iodized table salt? 24a.	(180) 1 ☐ Yes } *SKIP to 25a* 2 ☐ No } 3 ☐ Don't know – *Ask b*
b. May I see your box of table salt? b.	(181) 1 ☐ Iodized 2 ☐ Not iodized 3 ☐ No box
25a. What is the most that you have ever weighed? 25a.	(182) _ _ _Pounds
b. How old were you then? b.	(183) _ _Years old
INTERVIEWER CHECK ITEM	(184) 1 ☐ Ages 18 and over – *Ask 26a* 2 ☐ Under 18 – *SKIP to next "INTERVIEWER CHECK ITEM"*
26a. What is the least you have weighed since you were 18? 26a.	(185) _ _ _Pounds
b. How old were you then? b.	(186) _ _Years old
INTERVIEWER CHECK ITEM	(187) 1 ☐ Female – *Ask 27a* 2 ☐ Male – *END OF QUESTIONNAIRE*
27a. How old were you when your periods or menstrual cycles started? 27a.	(188) _ _Years – *Ask b* 02 ☐ Haven't started yet – *END OF QUESTIONNAIRE*
b. Have they entirely stopped? b.	(189) 1 ☐ Yes – *Ask c* 2 ☐ No – *SKIP to 28a*
c. At what age? c.	(190) _ _Years
28a. Have you taken birth control pills during the past six months? 28a.	(191) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 29a*
b. Are you taking them now? b.	(192) 1 ☐ Yes 2 ☐ No
29a. Are you or have you ever been pregnant? 29a.	(193) 1 ☐ Yes – *Ask b* 2 ☐ No – *END OF QUESTIONNAIRE*
b. What is the total number of pregnancies you have had? b.	(194) _ _ Number
c. What is the total number of miscarriages you have had? c.	(195) _ _ Number
d. What is the total number of live births you have had? d.	(196) _ _ Number
e. Are you pregnant now? e.	(197) 1 ☐ Yes – *Ask f* 2 ☐ No } *SKIP to g* 3 ☐ Don't know }
f. Which month of pregnancy are you in? f.	(198) _ _Month
g. Have you had a pregnancy which ended within the last twelve months? g.	(199) 1 ☐ Yes – *Ask h* 2 ☐ No – *END OF QUESTIONNAIRE*
h. How many months ago did that pregnancy end? h.	(200) 1 ☐ 10 – 12 months ago 2 ☐ 7 – 9 months ago 3 ☐ 4 – 6 months ago 4 ☐ 0 – 3 months ago
i. Are you breast feeding? i.	(201) 1 ☐ Yes 2 ☐ No

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

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

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

GENERAL MEDICAL HISTORY SUPPLEMENT – AGES 25–74

a. Name (Last, first, middle)	b. Deck No. 091	c. Sample No. _ _ _ _ _	d. Segment No. _ _ _ _ _ _

e. Serial No. _ _	f. Column No. _ _	g. Sex 1 ☐ Male 2 ☐ Female	h. Age _ _	i. Date of birth Month _ _	Day _ _	Year _ _

Question		Response
1. Would you say your health in general is excellent, very good, good, fair, or poor?	1.	(001) 1 ☐ Excellent 2 ☐ Very good 3 ☐ Good 4 ☐ Fair 5 ☐ Poor
2a. Do you have any health problems now that you would like to talk to a doctor about?	2a.	(002) 1 ☐ Yes – Ask b 2 ☐ No – SKIP to 3a
b. What are the problems? ______ ______	b.	DATA PREPARATION USE ONLY (003) 1 ☐ (007) 1 ☐ (011) 1 ☐ (015) 1 ☐ (004) 1 ☐ (008) 1 ☐ (012) 1 ☐ (016) 1 ☐ (005) 1 ☐ (009) 1 ☐ (013) 1 ☐ (017) 1 ☐ (006) 1 ☐ (010) 1 ☐ (014) 1 ☐
3a. Have you had a cold, flu or "the virus" during the past month?	3a.	(018) 1 ☐ Yes – Ask b 2 ☐ No – SKIP to 4a
b. Do you still have it?	b.	(019) 1 ☐ Yes 2 ☐ No
4a. In the past five years have you had any injury resulting in a broken bone?	4a.	(020) 1 ☐ Yes – Ask b 2 ☐ No – SKIP to 5
b. Which bone?	b.	Yes / No
Hip		(021) 1 ☐ 2 ☐
Wrist		(022) 1 ☐ 2 ☐
Spine		(023) 1 ☐ 2 ☐
Other (Specify) ______		(024) 1 ☐ 2 ☐
5. In the past five years have you had a back injury?	5.	(025) 1 ☐ Yes 2 ☐ No
6a. In the past year have you stayed in a hospital overnight or longer?	6a.	(026) 1 ☐ Yes – Ask b and c 2 ☐ No – SKIP to 7a
b. For what condition?	b.	DATA PREPARATION USE ONLY
(1) First ______		(027) _ _
(2) Second ______		(028) _ _
(3) Third ______		(029) _ _
c. How long were you in the hospital? (1) First condition	c.	(030) _ _ weeks 00 ☐ Less than one week
(2) Second condition		(031) _ _ weeks 00 ☐ Less than one week
(3) Third condition		(032) _ _ weeks 00 ☐ Less than one week
▶ USE OF TOBACCO 7a. Have you smoked at least 100 cigarettes during your entire life?	7a.	(033) 1 ☐ Yes – Ask b 2 ☐ No – SKIP to 8a
b. Do you smoke cigarettes now?	b.	(034) 1 ☐ Yes – Ask c 2 ☐ No – SKIP to d
c. On the average, about how many a day do you smoke?	c.	(035) _ _ _ cigarettes per day (Enter answer and SKIP to e)
d. How long has it been since you smoked cigarettes fairly regularly?	d.	(036) 77 ☐ Under one year – Ask e _ _ years – Enter number of years and SKIP to f 88 ☐ Never smoked cigarettes regularly – SKIP to 8a 99 ☐ Don't know – Ask e
e. On the average, about how many cigarettes a day were you smoking 12 months ago?	e.	(037) _ _ _ cigarettes per day 88 ☐ Did not smoke 99 ☐ Don't know
f. During the period when you were smoking the most, about how many cigarettes a day did you usually smoke?	f.	(038) _ _ _ cigarettes per day 99 ☐ Don't know
g. About how old were you when you first started smoking cigarettes fairly regularly?	g.	(039) _ _ years old 88 ☐ Never smoked regularly 99 ☐ Don't know

Question		Item	Response
8a. Have you smoked at least 50 cigars during your entire life?	8a.	(040)	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 9a*
b. Do you smoke cigars now?	b.	(041)	1 ☐ Yes – *Ask c* 2 ☐ No – *SKIP to e*
c. About how many cigars a day do you smoke?	c.	(042)	— — cigars per day – *SKIP to f* *(IF LESS THAN 1 PER DAY)* 88 ☐ 3 to 6 per week – *SKIP to f* 99 ☐ Less than 3 per week – *Ask d*
d. About how long has it been since you smoked 3 or more cigars a week?	d.	(043)	77 ☐ Under 1 year – *SKIP to f* — — years – *Enter number of years and SKIP to 9a* 88 ☐ Never smoked 3 or more cigars a week – *SKIP to 9a* 99 ☐ Don't know – *SKIP to f*
e. About how long has it been since you smoked 3 or more cigars a week?	e.	(044)	77 ☐ Under 1 year – *Ask f* — — years – *Enter number of years and SKIP to 9a* 88 ☐ Never smoked 3 or more cigars a week – *SKIP to 9a* 99 ☐ Don't know – *Ask f*
f. Twelve months ago, about how many cigars a day did you usually smoke?	f.	(045)	— — cigars per day *(IF LESS THAN 1 PER DAY)*
		(046)	1 ☐ 3 to 6 per week 2 ☐ Less than 3 per week 3 ☐ Did not smoke cigars
9a. Have you smoked at least 3 packages of pipe tobacco during your entire life?	9a.	(047)	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 10a*
b. Do you smoke a pipe now?	b.	(048)	1 ☐ Yes – *Ask c* 2 ☐ No – *SKIP to e*
c. About how many pipefuls of tobacco a day do you usually smoke?	c.	(049)	— — pipefuls per day – *SKIP to f on page 4* *(IF LESS THAN 1 PER DAY)*
		(050)	1 ☐ 3 to 6 per week – *SKIP to f on page 4* 2 ☐ Less than 3 per week – *Ask d*
d. About how long has it been since you smoked 3 or more pipefuls a week?	d.	(051)	77 ☐ Under 1 year – *SKIP to f on page 4* — — years – *Enter number of years and SKIP to 10a* 88 ☐ Never smoked 3 or more pipefuls a week – *SKIP to 10a* 99 ☐ Don't know – *SKIP to f on page 4*
e. About how long has it been since you smoked 3 or more pipefuls a week?	e.	(052)	77 ☐ Under 1 year – *Ask f on page 4* — — years – *Enter number of years and SKIP to 10a* 88 ☐ Never smoked 3 or more pipefuls a week – *SKIP to 10a* 99 ☐ Don't know – *Ask f on page 4*
f. Twelve months ago, about how many pipefuls a day did you smoke?	f.	(053)	— — pipefuls per day *(IF LESS THAN 1 PER DAY)*
		(054)	1 ☐ 3 to 6 per week 2 ☐ Less than 3 per week 3 ☐ Did not smoke a pipe
10a. Do you presently use any other form of tobacco, such as snuff or chewing tobacco?	10a.	(055)	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 11a*
b. What?	b.		Yes / No
Snuff		(056)	1 ☐ / 2 ☐
Chewing tobacco		(057)	1 ☐ / 2 ☐
Other *(Specify)* ______		(058)	1 ☐ / 2 ☐

HEARING

Question		Item	Response
11a. At any time over the past few years, have you ever noticed ringing in your ears, or have you been bothered by other funny noises in your ears?	11a.	(059)	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 12a*
b. How often?	b.	(060)	1 ☐ Every few days 2 ☐ Less often
c. Does it bother you?	c.	(061)	1 ☐ Quite a bit 2 ☐ Just a little 3 ☐ Not at all
12a. Have you ever had a running ear or any discharge from your ears (not counting wax in the ears)?	12a.	(062)	1 ☐ Yes – *Ask b* 2 ☐ No } *SKIP to 13a* 9 ☐ Don't know } *SKIP to 13a*
b. How often have you had this?	b.	(063)	1 ☐ Once only 2 ☐ Twice 3 ☐ Three or more times 9 ☐ Don't know
13a. Have you ever had deafness or trouble hearing with one or both ears?	13a.	(064)	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 14*
b. Did you ever see a doctor about it?	b.	(065)	1 ☐ Yes 2 ☐ No
c. How old were you when you first began having trouble hearing?	c.	(066)	1 ☐ 0–4 years old 2 ☐ 5–9 years old 3 ☐ 10–19 years old 4 ☐ 20–29 years old 5 ☐ 30–39 years old 6 ☐ 40–49 years old 7 ☐ 50 years old or older
d. Since this trouble began, has it gotten worse, gotten better, or stayed about the same?	d.	(067)	1 ☐ Gotten worse 2 ☐ Gotten better 3 ☐ Stayed about the same

13e. What was the cause of your hearing trouble or deafness?	13e.	Yes	No
Ear infection	(068)	1 ☐	2 ☐
Born with it	(069)	1 ☐	2 ☐
Loud noise (such as that from machinery, gun fire, blasts or explosions)	(070)	1 ☐	2 ☐
Ear surgery	(071)	1 ☐	2 ☐
Ear injury	(072)	1 ☐	2 ☐
Other (Specify) ________	(073)	1 ☐	2 ☐
Don't know	(074)	9 ☐	

Question		Code	Answer
f. How would you rate your hearing in your RIGHT ear?	f.	(075)	1 ☐ Good 2 ☐ A little decreased 3 ☐ A lot decreased 4 ☐ Deaf
g. How would you rate your hearing in your LEFT ear?	g.	(076)	1 ☐ Good 2 ☐ A little decreased 3 ☐ A lot decreased 4 ☐ Deaf
h. Have you ever attended a school or class for those with poor hearing or a school for the deaf?	h.	(077)	1 ☐ Yes 2 ☐ No
i. Have you ever had any training in lip reading?	i.	(078)	1 ☐ Yes 2 ☐ No
j. Have you ever had any training in speech or in speech correction because of poor hearing?	j.	(079)	1 ☐ Yes 2 ☐ No
k. Have you ever had any training in how to use your hearing?	k.	(080)	1 ☐ Yes 2 ☐ No
l. Have you ever had an operation on your ears?	l.	(081)	1 ☐ Yes 2 ☐ No
m. Have you ever had your hearing tested?	m.	(082)	1 ☐ Yes 2 ☐ No – *SKIP to p on page 6*
n. How old were you when your hearing was first tested?	n.	(083)	1 ☐ 0–9 years old 2 ☐ 10–19 years old 3 ☐ 20–29 years old 4 ☐ 30 years old or older
o. How often do you now have your hearing tested?	o.	(084)	1 ☐ Twice a year 2 ☐ Once a year 3 ☐ Once every two years 4 ☐ Less often than once every two years
p. Have you ever used a hearing aid?	p.	(085)	1 ☐ Yes 2 ☐ No – *SKIP TO 14*
q. Which ear?	q.	(086)	1 ☐ Right 2 ☐ Left 3 ☐ Both
r. With a hearing aid, is your hearing better?	r.	(087)	1 ☐ Yes 2 ☐ No

READ – The following series of questions will be about specific medical problems or conditions you might have had in the past, or might even have at the present time. Please answer "Yes" or "No" to each question.

14. Have you ever had--	14.	Code	Yes	No
a. Pain or aching in any of your joints either at rest or when moving them, this condition being present for AT LEAST ONE MONTH?	a.	(088)	1 ☐ Yes	2 ☐ No
b. Pain in your neck or back, this pain having been present for AT LEAST ONE MONTH?	b.	(089)	1 ☐ Yes	2 ☐ No
c. Pain in or around either hip joint (including the buttock, groin, and side of the upper thigh) or knee (including the the back of the knee), this pain having been present for AT LEAST ONE MONTH?	c.	(090)	1 ☐ Yes	2 ☐ No
d. Swelling of a joint, with pain present in the joint when touched, this condition present for AT LEAST ONE MONTH?	d.	(091)	1 ☐ Yes	2 ☐ No
e. Stiffness in the joints and muscles when getting out of bed in the morning, the stiffness lasting for AT LEAST 15 MINUTES?	e.	(092)	1 ☐ Yes	2 ☐ No
f. Trouble with recurring persistent cough attacks?	f.	(093)	1 ☐ Yes	2 ☐ No
g. A cough first thing in the morning in the winter? (Count a cough with first smoking or on first going out of doors; exclude clearing of throat or a single cough.)	g.	(094)	1 ☐ Yes	2 ☐ No
h A cough first thing in the morning in the summer?	h.	(095)	1 ☐ Yes	2 ☐ No
i. Any phlegm from your chest first thing in the morning in the winter? (Count phlegm with the first smoke or on going out of doors; excluding phlegm from the nose. (Count swallowed phlegm.)	i	(096)	1 ☐ Yes	2 ☐ No
j. Any phlegm from your chest the first thing in the morning in the summer?	j.	(097)	1 ☐ Yes	2 ☐ No
k. During the past three years, a period of increased cough and phlegm lasting for three weeks or more?	k.	(098)	1 ☐ Yes – How many times?	2 ☐ No – *SKIP to 14L*
		(099)	1 ☐ One time 2 ☐ Two times 3 ☐ More than two times	

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

i. When was the last time you saw a doctor about goiter or thyroid trouble?	i.	(131) 1 [ ] Less than one month ago 2 [ ] 1–3 months ago 3 [ ] 4–6 months ago 4 [ ] 7–11 months ago 5 [ ] 1 or more years ago 9 [ ] Don't know 6 [ ] Never

SKIN CONDITIONS

17a. Have you ever had any of the following skin conditions?	17a.		Yes	No
Acne or pimples		(132)	1 [ ]	2 [ ]
Psoriasis		(133)	1 [ ]	2 [ ]
Moles or birthmarks		(134)	1 [ ]	2 [ ]
Unusual loss of hair		(135)	1 [ ]	2 [ ]
Eczema		(136)	1 [ ]	2 [ ]
Warts		(137)	1 [ ]	2 [ ]
Hives		(138)	1 [ ]	2 [ ]

b. *If "Yes"* – Were you treated by a doctor for it?	b.		Yes	No
Acne or pimples		(139)	1 [ ]	2 [ ]
Psoriasis		(140)	1 [ ]	2 [ ]
Moles or birthmarks		(141)	1 [ ]	2 [ ]
Unusual loss of hair		(142)	1 [ ]	2 [ ]
Eczema		(143)	1 [ ]	2 [ ]
Warts		(144)	1 [ ]	2 [ ]
Hives		(145)	1 [ ]	2 [ ]

TEETH

18a. Have you lost all your teeth from your upper jaw?	18a.	(146) 1 [ ] Yes – *Ask b* 2 [ ] No – *SKIP to 19a*
b. Do you have a plate for your upper jaw?	b.	(147) 1 [ ] Yes – *Ask c* 2 [ ] No – *SKIP to d*
c. How long have you had your plate?	c.	(148) 1 [ ] Less than 1 year 2 [ ] 1–4 years 3 [ ] 5–9 years 4 [ ] 10–19 years 5 [ ] 20 or more years } *SKIP to 19a*
d. Have you ever had a dental plate for your upper jaw?	d.	(149) 1 [ ] Yes 2 [ ] No
e. How long has it been since you had any teeth to chew with (natural or false) in your upper jaw?	e.	(150) 1 [ ] Less than 1 year 2 [ ] 1–4 years 3 [ ] 5–9 years 4 [ ] 10–19 years 5 [ ] 20 or more years
19a. Have you lost all your teeth from your lower jaw?	19a.	(151) 1 [ ] Yes – *Ask b* 2 [ ] No – *SKIP to 20*
b. Do you have a plate for your lower jaw?	b.	(152) 1 [ ] Yes – *Ask c* 2 [ ] No – *SKIP to d*
c. How long have you had your plate?	c.	(153) 1 [ ] Less than 1 year 2 [ ] 1–4 years 3 [ ] 5–9 years 4 [ ] 10–19 years 5 [ ] 20 or more years } *SKIP to 20*
d. Have you ever had a dental plate for your lower jaw?	d.	(154) 1 [ ] Yes 2 [ ] No
e. How long has it been since you had any teeth to chew with in your lower jaw?	e.	(155) 1 [ ] Less than 1 year 2 [ ] 1–4 years 3 [ ] 5–9 years 4 [ ] 10–19 years 5 [ ] 20 or more years

Question		Item	Response
• *If the respondent doesn't have any full plates. ("No" to questions 18b and 19b) SKIP to the instructions above question 24.* **20. Do you usually wear your plate(s) while eating?**	**20.**	(156)	1 ☐ Yes 2 ☐ No
21. Do you usually wear your plate(s) when not eating?	**21.**	(157)	1 ☐ Yes 2 ☐ No
22. Do you usually use denture powder or cream to help keep your plate(s) in place?	**22.**	(158)	1 ☐ Yes 2 ☐ No
23. Do you think you need a new plate or that the one(s) you have need(s) refitting?	**23.**	(159)	1 ☐ No 2 ☐ Yes, one 3 ☐ Yes, both 9 ☐ Don't know
• *If respondent has no natural teeth. ("Yes" to questions 18a and 19a) questionnaire COMPLETED.* • *If the respondent has any natural teeth, CONTINUE.* **24. How would you describe the condition of your TEETH?**	**24.**	(160)	1 ☐ Excellent 2 ☐ Good 3 ☐ Fair 4 ☐ Poor
25. How would you describe the condition of your GUMS?	**25.**	(161)	1 ☐ Excellent 2 ☐ Good 3 ☐ Fair 4 ☐ Poor
26. Do you think that your teeth need cleaning now by a dentist or dental hygienist?	**26.**	(162)	1 ☐ Yes 2 ☐ No 9 ☐ Don't know
27. How many times a day do you usually brush your teeth?	**27.**	(163)	___ Times
28. Do you think that you ought to go to a dentist now or very soon for a checkup?	**28.**	(164)	1 ☐ Yes 2 ☐ No 9 ☐ Don't know
29. Do you now have an appointment to see a dentist?	**29.**	(165)	1 ☐ Yes 2 ☐ No
30. Do you think you have any teeth that need filling?	**30.**	(166)	1 ☐ Yes 2 ☐ No 9 ☐ Don't know
31a. Do you think you have any teeth that need to be pulled?	**31a.**	(167)	1 ☐ Yes – *Ask b* 2 ☐ No .... } SKIP to 32a 9 ☐ Don't know }
b. How many?	**b.**	(168)	1 ☐ Some 2 ☐ All
32a. Have you ever had your teeth cleaned by a dentist or dental hygienist?	**32a.**	(169)	1 ☐ Yes – *Ask b* 2 ☐ No – *END OF INTERVIEW*
b. When was the last time they were cleaned?	**b.**	(170)	1 ☐ Less than 1 year ago 2 ☐ 1–2 years ago 3 ☐ 3–4 years ago 4 ☐ 5 or more years ago
		(171)	
		(172)	

NOTES

HSM 425-16
REV. 4-71

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

FORM APPROVED
O.M.B. NO. 68-R1164

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DIETARY - 24 HOUR RECALL

NAME: ______________________

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

PUNCH A NEW CARD FOR EACH FOOD ITEM

ING. PER. (36)	FOOD CODE (37 - 41)	FOODS AND BEVERAGES CONSUMED		WORK AREA FOR COMPUTATIONS (If needed)	SIZE OF EDIBLE PORTION SERVED			TIME OF DAY (57-60)	FOOD SOURCE CODE (61)	LINE CARD NO. (62-63)
		FOOD ITEM	DESCRIPTION		I (42 - 46)	II (47 - 51)	III (52 - 56)			
										01
										02
										03
										04
										05
										06
										07
										08
										09
										10
										11
										12
										13
										14
										15
										16
										17
										18
										19
										20
										21
										22
										23
										24

RESPONDENT CODE

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

"SEX" CODE (Use highest applicable code)

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

INGESTION PERIOD CODE

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

FOOD SOURCE CODE

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

HSM-425-16 (BACK) (REV. 4-71)

ING. PER. (36)	FOOD CODE (37 - 41)	FOODS AND BEVERAGES CONSUMED: FOOD ITEM	FOODS AND BEVERAGES CONSUMED: DESCRIPTION	WORK AREA FOR COMPUTATIONS *(If needed)*	SIZE OF EDIBLE PORTION SERVED: I (42-46)	SIZE OF EDIBLE PORTION SERVED: II (47-51)	SIZE OF EDIBLE PORTION SERVED: III (52-56)	TIME OF DAY (57-60)	FOOD SOURCE CODE (61)	LINE CARD NO. (62-63)
										25
										26
										27
										28
										29
										30
										31
										32
										33
										34
										35
										36
										37
										38
										39
										40
										41
										42
										43
										44
										45
										46

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

FOOD SOURCE CODE
1 - HOME
2 - SCHOOL
3 - RESTAURANT
4 - OTHER

COMPLETION CODE
1 - COMPLETED SATISFACTORY
2 - UNSATISFACTORY (SPECIFY) ________________
3 - REFUSAL
4 - NOT AVAILABLE
5 - INFORMANT INCAPABLE
6 - OTHER

IS WHAT YOU ATE YESTERDAY THE WAY YOU USUALLY EAT? (64) ☐
1 - YES
2 - NO, ILL
3 - NO; NO MONEY
4 - NO; SUNDAY OR HOLIDAY
5 - NO; OTHER REASON (SPECIFY) ________________

HAS YOUR DIET CHANGED RECENTLY? (65) ☐
0 - NO CHANGE
1 - YES; EATING MORE
3 - YES; EATING LESS
4 - YES, ON A PRESCRIBED DIET

ARE YOU TAKING VITAMINS OR MINERALS? (66) ☐
0 - NO
1 - YES, REGULARLY
2 - YES, IRREGULARLY

IF YES - INTERVIEWER - *(See Guidelines)* (67) ☐
1 - MULTIPLE VITAMINS
2 - MULTIPLE VITAMINS AND MINERALS
3 - IRON ONLY
4 - MULTIPLE VITAMINS AND IRON
5 - OTHER (SPECIFY) ________________
8 - N. A.

HOW MANY TIMES A WEEK DO YOU EAT A MEAL AT A RESTAURANT? (68) ☐
0 - SELDOM, NEVER
1 - 1-3 TIMES
2 - 4-6 TIMES
3 - 7 OR MORE TIMES

INTERVIEWER: Ask only if respondent age 20 or over.
HOW OFTEN DO YOU USE THE SALT SHAKER AT THE TABLE? (69) ☐
0 - RARELY, NEVER
1 - OCCASIONALLY, SELDOM
2 - FREQUENTLY, ALWAYS
8 - N. A.

INTERVIEWER'S CODE (75 - 77) ☐☐☐

COMPLETION CODE (78) ☐

CARD NO. (79 - 80) | 0 | 3 |

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

FORM APPROVED
O.M.B. NO. 68-R1184

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HSM 425-18
REV. 4/71

DIETARY – FREQUENCY

NAME ____________________

BEGIN CARD NO. 1

SAMPLE NO. (1 - 5)	SEGMENT (6 - 11)	SERIAL (12-13)	COLUMN (14-15)	RESP. CODE (16)	DATE OF BIRTH (17 - 22) MO. DAY YEAR	"SEX" (23)	DATE OF INTERVIEW (24 - 29) MO. DAY YEAR

Item	NO. OF TIMES	INTERVAL (0 D1 W2 7 9)
1. MILK (BEVERAGE AND ON CEREALS) A) WHOLE FRESH MILK	(30-31)	(32)
B) SKIM MILK OR BUTTERMILK	(33-34)	(35)
2. MEAT AND POULTRY All kinds such as beef, pork, lamb, veal, chicken, turkey, etc.	(36-37)	(38)
3. FISH OR SHELL FISH	(39-40)	(41)
4. EGGS	(42-43)	(44)
5. CHEESE AND CHEESE DISHES	(45-46)	(47)
6. DRY BEANS AND PEAS like Pinto beans, red beans, black-eye peas, peanuts and peanut butter	(48-49)	(50)
7. FRUITS AND VEGETABLES A) ALL KINDS - FRESH, CANNED, FROZEN, COOKED, OR RAW, JUICES	(51-52)	(53)
B) FRUITS AND VEGETABLES RICH IN VITAMIN A *(See guidelines)*	(54-55)	(56)
C) FRUITS AND VEGETABLES RICH IN VITAMIN C *(See guidelines)*	(57-58)	(59)
8. BREAD A) BREAD, ROLLS, BISCUITS, MUFFINS, CORNBREAD	(60-61)	(62)
B) BREAKFAST CEREALS EITHER DRY AS CORNFLAKES OR COOKED SUCH AS OATMEAL	(63-64)	(65)
9. BUTTER AND MARGARINE	(66-67)	(68)
10. DESSERTS AND SWEETS such as: cake, pie, cookies, puddings, ice cream	(69-70)	(71)
11. "CANDY"	(72-73)	(74)

CARD NO. 1 (79 - 80) 0 1

BEGIN CARD NO. 2 Repeat Columns 1-16 from Card No. 1

Item	NO. OF TIMES	INTERVAL (0 D1 W2 7 9)
12. BEVERAGES A) COLD DRINKS, SUCH AS SODA, COLA, LEMONADE, KOOL-AID, MADE WITH SUGAR	(17-18)	(19)
B) COLD DRINKS, AS ABOVE, ARTIFICIALLY SWEETENED OR "DIET" DRINKS	(20-21)	(22)
C) COFFEE OR TEA	(23-24)	(25)
13. SNACK FOODS (potato chips, corn chips, cheese snacks, etc.)	(26-27)	(28)

INTERVIEWER'S CODE (75 - 77) COMPLETION CODE (78) CARD NO. 2 (79 - 80) 0 2

NO. OF TIMES CODE
00-NONE OR NEVER
99-UNKNOWN
77-LESS THAN ONCE A WEEK

INTERVAL CODE
0-NEVER
1-DAILY
2-WEEKLY
7-LESS THAN ONCE A WEEK
9-UNKNOWN

"SEX" CODE (Use highest applicable code)
1-MALE
2-FEMALE EXCEPT PREG. OR BREAST FEEDING
3-PREG. 1-4 MOS.
4-PREG. 5-9 MOS.
5-BREAST FEEDING
6-BREAST FEEDING/ PREG. 1-4 MOS.
7-BREAST FEEDING/ PREG. 5-9 MOS.

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

COMPLETION CODE
1-COMPLETED SATISFACTORY
2-COMPLETED UNSATISFACTORY (SPECIFY) ____________
3-REFUSAL
4-NOT AVAILABLE
5-INFORMANT INCAPABLE
6-OTHER

APPENDIX IIJ. HEALTH CARE NEEDS QUESTIONNAIRE

HSM-411-6 (PAGE 1)
REV. 9/71

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

HEALTH CARE NEEDS

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

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

a. Name (*Last, first, middle*)

b. Deck No.	c. Sample No.	d. Segment No.	e. Serial No.	f. Column No.
181	_ _ _ _ _	_ _ _ _ _ _	_ _	_ _

READ – I need to ask you a number of questions about doctors, dentists, hospitals, and other people who might give you medical care, just how you use them, and what your opinion is on some questions about health care. Your answers will be kept confidential.

DOCTORS

1. When was the last time you talked to a doctor about your own health . .

1.		Never	Less than 2 weeks ago	2 Weeks through 5 months ago	6 through 11 months ago	1 but less than 2 years ago	2 through 4 years ago	5 or more years ago
at a private doctor's office?	001	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
at a hospital outpatient clinic? . . .	002	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
at a city clinic?	003	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
at a clinic at work?	004	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
at another type clinic?	005	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
at a hospital emergency room?	006	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
at home?	007	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
over the telephone?	008	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
in another way? – *Specify* ____________	009	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

2. What was the MAIN reason for your last visit with a doctor? (*Check only one.*)

2. (010)
1 ☐ A sickness or illness – What was the problem? ____________
2 ☐ An injury– What was the problem? ____________
3 ☐ A follow-up visit
4 ☐ A regular checkup
5 ☐ An injection
6 ☐ For a prescription
7 ☐ Some other reason

3a. For this last visit, how long was it from the time you decided you should see a doctor until you actually saw him:

3a. (011)
1 ☐ Less than one day
2 ☐ 1–6 days
3 ☐ 1 but less than 2 weeks
4 ☐ 2–3 weeks
5 ☐ 1–2 months
6 ☐ 3 months or more
9 ☐ Don't remember

b. Did you have an appointment to see him?

b. (012)
1 ☐ Yes – *Ask c*
2 ☐ No – *SKIP to 4*

c. How long was it from the time you made the appointment until you saw him?

c. (013)
1 ☐ Less than one day
2 ☐ 1–6 days
3 ☐ 1 but less than 2 weeks
4 ☐ 2–3 weeks
5 ☐ 1–2 months
6 ☐ 3 months or more
9 ☐ Don't remember

d. Was this time longer than you would have liked?

d. (014)
1 ☐ Yes
2 ☐ No
9 ☐ Don't remember

4. From what place did you leave to go to the doctor?

4. (015)
1 ☐ From home
2 ☐ From work
3 ☐ From some other place

5. How did you get from there to the doctor?

5. (016)
1 ☐ Walked
2 ☐ Bus
3 ☐ Own car
4 ☐ Someone else's car
5 ☐ Cab
6 ☐ Ambulance
7 ☐ Other means

6. How long did it take to get there?

6. (017)
1 ☐ Less than 15 minutes
2 ☐ 15–29 minutes
3 ☐ 30–59 minutes
4 ☐ 1 hour or more
9 ☐ Don't remember

7a. At this last visit, about how many minutes did you have to wait before being seen by the doctor?

7a. (018) _ _ _ minutes

b. Do you think this wait was too long?

b. (019)
1 ☐ Yes
2 ☐ No

8. How well satisfied were you with this visit?

8. (020)
1 ☐ *Satisfied*
2 ☐ Not completely satisfied
3 ☐ Dissatisfied
4 ☐ No opinion

9a. During the past 12 months, have you had a health problem which you would have liked to see a doctor about but did not for some reason?

9a. (021)
1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 10*

b. What was the reason you did not see a doctor?

b.		Yes	No
Lack of confidence in available doctors	(022)	1 ☐	2 ☐
Didn't have time	(023)	1 ☐	2 ☐
Would cost too much	(024)	1 ☐	2 ☐
Couldn't get an appointment	(025)	1 ☐	2 ☐
Would have to travel too far	(026)	1 ☐	2 ☐
Didn't have a way to get there	(027)	1 ☐	2 ☐
Was afraid of finding out what was wrong	(028)	1 ☐	2 ☐
Didn't have anyone to care for *children or other family members*	(029)	1 ☐	2 ☐
Other – *Specify* ______	(030)	1 ☐	2 ☐

10a. When did you last have a general checkup or examination, not counting exams made during a visit for an illness?

10. (031)
1 ☐ Never – *SKIP to 13*
2 ☐ Less than 6 months ago
3 ☐ 6–11 months ago
4 ☐ 1 but less than 2 years ago
5 ☐ 2 years ago or more
9 ☐ Don't remember

11. Where did you get this general examination?

11. (032)
1 ☐ Doctor's office
2 ☐ Hospital clinic
3 ☐ Another clinic
4 ☐ *Some other place – Specify* ______

12. During this last general examination, were you given –

12.		Yes	No	
a cardiogram?	(033)	1 ☐	2 ☐	
a blood pressure check?	(034)	1 ☐	2 ☐	
a chest x-ray?	(035)	1 ☐	2 ☐	
blood tests?	(036)	1 ☐	2 ☐	
a urinalysis?	(037)	1 ☐	2 ☐	
vision tests?	(038)	1 ☐	2 ☐	
hearing tests?	(039)	1 ☐	2 ☐	
a rectal examination?	(040)	1 ☐	2 ☐	
an internal examination *(FEMALES ONLY)*?	(041)	1 ☐	2 ☐	8 ☐ Not applicable

13a. When was the last time you received any *shots, immunizations or vaccinations* to prevent an illness, excluding shots for allergy?

13a. (042)
1 ☐ Never – *SKIP to 14*
2 ☐ Less than 6 months ago
3 ☐ 6–11 months ago
4 ☐ 1–2 years ago
5 ☐ 3–5 years ago
6 ☐ 6–9 years ago
7 ☐ 10 years ago or more
9 ☐ Don't remember

b. Why did you get this shot?

b. (043)
1 ☐ Foreign travel
2 ☐ During military service
3 ☐ Participation in community or work-sponsored immunization campaign *(for example, polio or flu)*
4 ☐ Other – *Specify* ______

14a. Is there a *particular doctor* you see regularly or whom you would go to if something were bothering you?

14a. (044)
1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 15*

b. If you couldn't see this doctor, is there some other particular doctor you would want to see if something were bothering you?

b. (045)
1 ☐ Yes
2 ☐ No
9 ☐ *Don't know*

15. Except in an emergency, do you need to *have an appointment in order to see a* doctor?

15. (046)
1 ☐ Yes
2 ☐ No

16. When you go to a doctor, do you like the doctor to talk to you about your condition or do you like him just to treat it?

16. (047)
1 ☐ Talk
2 ☐ Just treat

17. Do the doctors you usually see talk to you about your condition?

17. (048)
1 ☐ Yes
2 ☐ No

18. Do you try out home remedies or any that you can get without a prescription before going to your doctor about a problem?

18. (049)
1 ☐ *Yes, often*
2 ☐ Yes, sometimes
3 ☐ No

NOTES

▶ DENTIST

19. Do you have a dentist you usually go to?

19. (050) 1 ☐ Yes
2 ☐ No

20. When was the last time you visited or talked with a dentist about yourself. . . . .

20.		Never	Less than 6 months ago	6 through 11 months ago	1 but less than 2 years ago	2 through 4 years ago	5 or more years ago
at a dentist's office?	(051)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
at a hospital dental clinic? . . .	(052)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
at a hospital emergency clinic?	(053)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
at another clinic (work, school, etc.)	(054)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
over the telephone?	(055)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
in another way? – *Specify* ________	(056)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

21. What was the MAIN reason for your last visit or talk with a dentist at either his office or *at a clinic*?

21. (057) 1 ☐ Adjustment or repair of dental plate
2 ☐ To have a dental plate made
3 ☐ Toothache
4 ☐ Tooth pulled or other surgery
5 ☐ Trouble with gums
6 ☐ Regular checkup visit
7 ☐ For cleaning teeth
8 ☐ To have teeth filled
9 ☐ For a prescription
0 ☐ Some other reason – *Specify* ________

22. For this last visit, how long was it from the time you decided you *needed or wanted to see a dentist* until you actually saw him?

22. (058) 1 ☐ Less than one day
2 ☐ *1–6 days*
3 ☐ 1 week but less than 2 weeks
4 ☐ 2–3 weeks
5 ☐ 1–2 months
6 ☐ 3 months or more
9 ☐ Don't remember

23a. At the time of this last visit or talk with a dentist did you have an appointment?

23a. (059) 1 ☐ Yes – *Ask 23b*
2 ☐ No – *SKIP to 24*

b. How long was it from the time you made the appointment until you saw him?

b. (060) 1 ☐ Less than one day
2 ☐ 1–6 days
3 ☐ 1 week but less than 2 weeks
4 ☐ 2–3 weeks
5 ☐ 1–2 months
6 ☐ 3 months or more
9 ☐ Don't remember

c. Was this wait longer than you would have liked it?

c. (061) 1 ☐ Yes
2 ☐ No
9 ☐ Don't remember

24. How did you get to the dentist's office?

24. (062) 1 ☐ Walked
2 ☐ Bus or subway
3 ☐ Car
4 ☐ Cab
5 ☐ Other means – Specify ________

25. How long did it take to get there?

25. (063) 1 ☐ Less than 15 minutes
2 ☐ *15–29 minutes*
3 ☐ 30–59 minutes
4 ☐ 1 hour or more
9 ☐ *Don't remember*

26a. At this last visit with a dentist, about how many minutes did you have to wait before being seen by the dentist?

26a. (064) _ _ _ minutes

b. Do you think this wait was too long?

b. (065) 1 ☐ Yes
2 ☐ No

27. How well satisfied were you with this visit?

27. (066) 1 ☐ Satisfied
2 ☐ Not completely satisfied
3 ☐ Dissatisfied
4 ☐ No opinion

28. Does your dentist or dental clinic call you or send you a note to remind you *when your next regular checkup is due?*

28. (067) 1 ☐ Yes
2 ☐ No
9 ☐ *Don't know*

29a. During the past 12 months, have you had a dental problem which you would have liked to see a dentist about but you didn't see the dentist?

29a. (068) 1 ☐ Yes – *Ask 29b*
2 ☐ No – *SKIP to 30*

29b. *Why didn't you see him?*

29b.		Yes	No
Didn't have time	(069)	1 ☐	2 ☐
Would cost too much	(070)	1 ☐	2 ☐
Couldn't get an appointment	(071)	1 ☐	2 ☐
Would have to travel too far	(072)	1 ☐	2 ☐
Didn't have a way to get there	(073)	1 ☐	2 ☐
Didn't have anyone to care for children or other family members	(074)	1 ☐	2 ☐
Some other reason	(075)	1 ☐	2 ☐

HOSPITAL

30. When was the last time you stayed in a hospital overnight or longer?

30. (876)
- 1 ☐ Never – *SKIP to 36*
- 2 ☐ Less than 1 month ago
- 3 ☐ 1–5 months ago
- 4 ☐ 6–11 months ago
- 5 ☐ One year ago or more
- 9 ☐ Don't remember

31. Was this stay in the hospital on account of an emergency or was it planned in advance?

31. (877)
- 1 ☐ Planned
- 2 ☐ Emergency

32. What was the MAIN reason you went into the hospital that time?

32. (878)
- 1 ☐ Sickness or illness
- 2 ☐ Injury
- 3 ☐ Surgery
- 4 ☐ Child birth } *SKIP to 34*
- 5 ☐ Checkup } *SKIP to 34*
- 6 ☐ Some other reason – *Specify and SKIP to 34* ____________

33a. When you went into the hospital for this ______, just what was the problem?

____

____

b. How long was it from the time it was decided you needed to go into the hospital until you went in?

b. (879)
- 1 ☐ Less than one day
- 2 ☐ 1–6 days
- 3 ☐ 1 but less than 2 weeks
- 4 ☐ 2–3 weeks
- 5 ☐ 1–2 months
- 6 ☐ 3 months or more
- 9 ☐ Don't remember

34a. What part of the doctor's bill did you or your family have to pay out of your own pocket for the treatment the doctor gave you while you were in the hospital?

34a. (880)
- 1 ☐ None – *SKIP to 35*
- 2 ☐ Less than half
- 3 ☐ More than half, but not all
- 4 ☐ All
- 9 ☐ Don't know – *SKIP to 35*

b. Did you get any of this money back from your health insurance?

b. (881)
- 1 ☐ Yes
- 2 ☐ No

35a. What part of this hospital bill did you or your family have to pay out of your own pocket?

35a. (882)
- 1 ☐ None – *SKIP to 36*
- 2 ☐ Less than half
- 3 ☐ More than half, but not all
- 4 ☐ All
- 9 ☐ Don't know – *SKIP to 36*

b. Did you get any of this money back from your health insurance?

b. (883)
- 1 ☐ Yes
- 2 ☐ No

36a. When you see a doctor at his office or at a clinic, what part of the cost do you or your family usually have to pay out of your own pocket?

36a. (884)
- 1 ☐ Never been to a doctor – *SKIP to 37*
- 2 ☐ None – *SKIP to 37*
- 3 ☐ Less than half
- 4 ☐ More than half, but not all
- 5 ☐ All
- 9 ☐ Don't know – *SKIP to 37*

b. Do you get any of this money back from your health insurance?

b. (885)
- 1 ☐ Yes
- 2 ☐ No

37a. Whenever you see a dentist at either his office or at a clinic, what part of the cost do you or your family have to pay out of your own pocket?

37a. (886)
- 1 ☐ Never been to a dentist – *SKIP to 38*
- 2 ☐ None – *SKIP to 38*
- 3 ☐ Less than half
- 4 ☐ More than half, but not all
- 5 ☐ All
- 9 ☐ Don't know – *SKIP to 38*

b. Do you get any of this money back from your health insurance?

b. (887)
- 1 ☐ Yes
- 2 ☐ No

38a. What part of the cost of drugs and medicines prescribed by your doctor do you pay out of your own pocket?

38a. (888)
- 1 ☐ No drugs or medicines ever prescribed – *SKIP to 39*
- 2 ☐ None – *SKIP to 39*
- 3 ☐ Less than half
- 4 ☐ More than half, but not all
- 5 ☐ All
- 9 ☐ Don't know – *SKIP to 39*

b. Do you get any of this money back from your health insurance?

b. (889)
- 1 ☐ Yes
- 2 ☐ No

39. Do you have insurance or coverage for medical care under . . . .

39. / **39b. What part of your medical bills does it pay?**

		Yes	No		Less than half	More than half but not all	All	Don't know
Medicare (for elderly)?	(890)	1 ☐	2 ☐	(098)	1 ☐	2 ☐	3 ☐	9 ☐
Private medical insurance?	(891)	1 ☐	2 ☐	(099)	1 ☐	2 ☐	3 ☐	9 ☐
Insurance through your place of work?	(892)	1 ☐	2 ☐	(100)	1 ☐	2 ☐	3 ☐	9 ☐
Medicaid (for all ages) ?	(893)	1 ☐	2 ☐	(101)	1 ☐	2 ☐	3 ☐	9 ☐
Retired military privileges? . . .	(894)	1 ☐	2 ☐	(102)	1 ☐	2 ☐	3 ☐	9 ☐
Veterans medical care?	(895)	1 ☐	2 ☐	(103)	1 ☐	2 ☐	3 ☐	9 ☐
Some other government assistance program? – *Specify* ________	(896)	1 ☐	2 ☐	(104)	1 ☐	2 ☐	3 ☐	9 ☐
Some other way?	(897)	1 ☐	2 ☐	(105)	1 ☐	2 ☐	3 ☐	9 ☐

APPENDIX IIK. GENERAL WELL-BEING QUESTIONNAIRE

HSM-411-7 (PAGE 1)
REV. 8/71

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

GENERAL WELL-BEING

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

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

a. Name (Last, first, middle)	b. Deck No.	c. Sample No.	d. Sex	e. Age
	171	— — — — —	1 ☐ Male 2 ☐ Female	— —

READ – This section of the examination contains questions about how you feel and how things have been going with you. For each question, mark (X) the answer which best applies to you.

1. How have you been feeling in general? (DURING THE PAST MONTH)
1. (001)
1 ☐ In excellent spirits
2 ☐ In very good spirits
3 ☐ In good spirits mostly
4 ☐ I have been up and down in spirits a lot
5 ☐ In low spirits mostly
6 ☐ In very low spirits

2. Have you been bothered by nervousness or your "nerves"? (DURING THE PAST MONTH)
2. (002)
1 ☐ Extremely so -- to the point where I could not work or take care of things
2 ☐ Very much so
3 ☐ Quite a bit
4 ☐ Some -- enough to bother me
5 ☐ A little
6 ☐ Not at all

3. Have you been in firm control of your behavior, thoughts, emotions OR feelings? (DURING THE PAST MONTH)
3. (003)
1 ☐ Yes, definitely so
2 ☐ Yes, for the most part
3 ☐ Generally so
4 ☐ Not too well
5 ☐ No, and I am somewhat disturbed
6 ☐ No, and I am very disturbed

4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (DURING THE PAST MONTH)
4. (004)
1 ☐ Extremely so -- to the point that I have just about given up
2 ☐ Very much so
3 ☐ Quite a bit
4 ☐ Some - - enough to bother me
5 ☐ A little bit
6 ☐ Not at all

5. Have you been under or felt you were under any strain, stress, or pressure? (DURING THE PAST MONTH)
5. (005)
1 ☐ Yes -- almost more than I could bear or stand
2 ☐ Yes -- quite a bit of pressure
3 ☐ Yes -- some - more than usual
4 ☐ Yes -- some - but about usual
5 ☐ Yes - a little
6 ☐ Not at all

6. How happy, satisfied, or pleased have you been with your personal life? (DURING THE PAST MONTH)
6. (006)
1 ☐ Extremely happy – could not have been more satisfied or pleased
2 ☐ Very happy
3 ☐ Fairly happy
4 ☐ Satisfied -- pleased
5 ☐ Somewhat dissatisfied
6 ☐ Very dissatisfied

7. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? (DURING THE PAST MONTH)
7. (007)
1 ☐ Not at all
2 ☐ Only a little
3 ☐ Some -- but not enough to be concerned or worried about
4 ☐ Some and I have been a little concerned
5 ☐ Some and I am quite concerned
6 ☐ Yes, very much so and I am very concerned

8. Have you been anxious, worried, or upset? (DURING THE PAST MONTH)
8. (008)
1 ☐ Extremely so -- to the point of being sick or almost sick
2 ☐ Very much so
3 ☐ Quite a bit
4 ☐ Some -- enough to bother me
5 ☐ A little bit
6 ☐ Not at all

9. Have you been waking up fresh and rested? (DURING THE PAST MONTH)
9. (009)
1 ☐ Every day
2 ☐ Most every day
3 ☐ Fairly often
4 ☐ Less than half the time
5 ☐ Rarely
6 ☐ None of the time

10. Have you been bothered by any illness, bodily disorder, pains, or fears about your health? (DURING THE PAST MONTH)
10. (010)
1 ☐ All the time
2 ☐ Most of the time
3 ☐ A good bit of the time
4 ☐ Some of the time
5 ☐ A little of the time
6 ☐ None of the time

11. Has your daily life been full of things that were interesting to you? (DURING THE PAST MONTH)
11. (011)
1 ☐ All the time
2 ☐ Most of the time
3 ☐ A good bit of the time
4 ☐ Some of the time
5 ☐ A little of the time
6 ☐ None of the time

12. Have you felt down-hearted and blue? (DURING THE PAST MONTH)
12. (012)
1 ☐ All of the time
2 ☐ Most of the time
3 ☐ A good bit of the time
4 ☐ Some of the time
5 ☐ A little of the time
6 ☐ None of the time

Question		Code	Response
13. Have you been feeling emotionally stable and sure of yourself? *(DURING THE PAST MONTH)*	13.	(013)	1 ☐ All of the time 2 ☐ Most of the time 3 ☐ A good bit of the time 4 ☐ Some of the time 5 ☐ A little of the time 6 ☐ None of the time
14. Have you felt tired, worn out, used-up, or exhausted? *(DURING THE PAST MONTH)*	14.	(014)	1 ☐ All of the time 2 ☐ Most of the time 3 ☐ A good bit of the time 4 ☐ Some of the time 5 ☐ A little of the time 6 ☐ None of the time
			For each of the four scales below, note that the words at each end of the 0 to 10 scale describe opposite feelings. Circle any number along the bar which seems closest to how you have generally felt DURING THE PAST MONTH.
15. How concerned or worried about your HEALTH have you been? *(DURING THE PAST MONTH)*	15.	(015)	0 1 2 3 4 5 6 7 8 9 10 Not concerned at all — Very concerned
16. How RELAXED or TENSE have you been? *(DURING THE PAST MONTH)*	16.	(016)	0 1 2 3 4 5 6 7 8 9 10 Very relaxed — Very tense
17. How much ENERGY, PEP, VITALITY have you felt? (DURING THE PAST MONTH)	17.	(017)	0 1 2 3 4 5 6 7 8 9 10 No energy AT ALL, listless — Very ENERGETIC, dynamic
18. How DEPRESSED or CHEERFUL have you been? *(DURING THE PAST MONTH)*	18.	(018)	0 1 2 3 4 5 6 7 8 9 10 Very depressed — Very cheerful
19. Have you had severe enough personal, emotional, behavior, or mental problems that you felt you needed help *DURING THE PAST YEAR?*	19.	(019)	1 ☐ Yes, and I did seek professional help 2 ☐ Yes, but I did not seek professional help 3 ☐ I have had (or have now) severe personal problems, but have not felt I needed professional help 4 ☐ I have had very few personal problems of any serious concern 5 ☐ I have not been bothered at all by personal problems during the past year
20. Have you ever felt that you were going to have, or were close to having, a nervous breakdown?	20.	(020)	1 ☐ Yes -- during the past year 2 ☐ Yes -- more than a year ago 3 ☐ No
21. *Have you ever had a nervous* breakdown?	21.	(021)	1 ☐ Yes -- during the past year 2 ☐ Yes -- more than a year ago 3 ☐ No
22. Have you ever been a patient *(or outpatient)* at a mental hospital, a mental health ward of a hospital, or a mental health clinic, for any personal, emotional, behavior, or mental problem.	22.	(022)	1 ☐ Yes -- during the past year 2 ☐ Yes -- more than a year ago 3 ☐ No
23. Have you ever seen a psychiatrist, psychologist, or psychoanalyst about any personal, emotional, behavior, or mental problem concerning yourself?	23.	(023)	1 ☐ Yes -- during the past year 2 ☐ Yes -- more than a year ago 3 ☐ No
24. Have you talked with or had any connection with any of the following about some personal, emotional, behavior, mental problem, worries, or "nerves" CONCERNING YOURSELF DURING *THE PAST YEAR?*			
a. Regular medical doctor (except for definite physical conditions or routine check-ups)	24a.	(024)	1 ☐ Yes 2 ☐ No
b. Brain or nerve specialist	b.	(025)	1 ☐ Yes 2 ☐ No
c. Nurse (except for routine medical conditions)	c.	(026)	1 ☐ Yes 2 ☐ No
d. Lawyer (except for routine legal services)	d.	(027)	1 ☐ Yes 2 ☐ No
e. Police (except for simple traffic violations)	e.	(028)	1 ☐ Yes 2 ☐ No
f. Clergyman, minister, priest, rabbi, etc.	f.	(029)	1 ☐ Yes 2 ☐ No
g. Marriage Counselor	g.	(030)	1 ☐ Yes 2 ☐ No
h. Social Worker	h.	(031)	1 ☐ Yes 2 ☐ No
i. Other formal assistance:	i.	(032)	1 ☐ Yes – What kind? ____________ 2 ☐ No
25. Do you discuss your problems with any members of your family or friends?	25.	(033)	1 ☐ Yes - and it helps a lot 2 ☐ Yes - and it helps some 3 ☐ Yes - but it does not help at all 4 ☐ No - I do not have anyone I can talk with about my problems 5 ☐ No - no one cares to hear about my problems 6 ☐ No - I do not care to talk about my problems with anyone 7 ☐ No - I do not have any problems
26. Filled out by:	26.	(034)	1 ☐ *Examinee* 2 ☐ *Interviewer* 3 ☐ Mixed

APPENDIX III. SUPPLEMENT A

HSM-411-2 (PAGE 1)
REV. 8/71

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

SUPPLEMENT A – ARTHRITIS

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

Name (Last, first, middle)	Deck No.	Sample No.
	121	— — — — —

READ – Earlier you mentioned having had either pain in a joint or in the back or neck, swelling of a joint, or morning stiffness in the joints or muscles. Here are some additional questions about it.

1a. Have you had pain in either the back or neck on most days for at least one month?
(001) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 2a*

b. Has this pain in the back or neck been present on any one occasion for at least six weeks?
(002) 1 ☐ Yes
2 ☐ No

c. Where is the pain usually located?

		Yes	No
Neck	(003)	1 ☐	2 ☐
Upper back	(004)	1 ☐	2 ☐
Mid-back	(005)	1 ☐	2 ☐
Lower back	(006)	1 ☐	2 ☐

d. When you have this pain, where is it most intense?

		Yes	No
Neck	(007)	1 ☐	2 ☐
Upper back	(008)	1 ☐	2 ☐
Mid-back	(009)	1 ☐	2 ☐
Lower back	(010)	1 ☐	2 ☐

e. Is the pain present when you are resting at night?
(011) 1 ☐ Yes
2 ☐ No

f. When you have the pain, does it awaken you from sleep at night?
(012) 1 ☐ Yes
2 ☐ No

g. Does the pain in the back ever seem to spread?
(013) 1 ☐ Yes
2 ☐ No
3 ☐ Not applicable, no pain in back

h. Where does it spread to?

		Yes	No
To the back of the right leg	(014)	1 ☐	2 ☐
To the back of the left leg	(015)	1 ☐	2 ☐
To the back of both legs	(016)	1 ☐	2 ☐
To the top of the head	(017)	1 ☐	2 ☐
To the sides of the body	(018)	1 ☐	2 ☐

i. Has pain in the neck ever seemed to spread?
(019) 1 ☐ Yes
2 ☐ No
3 ☐ Not applicable, no pain in neck

j. Where does it spread to?

		Yes	No
To the top and back of the head	(020)	1 ☐	2 ☐
To either shoulder area	(021)	1 ☐	2 ☐
To the arms or hands	(022)	1 ☐	2 ☐
Other – *Specify* ________	(023)	1 ☐	2 ☐

k. Is your back or neck pain made worse –

		Yes	No
by coughing, sneezing, or deep breathing?	(024)	1 ☐	2 ☐
with bending or twisting motion?	(025)	1 ☐	2 ☐
after prolonged activity?	(026)	1 ☐	2 ☐
after prolonged sitting?	(027)	1 ☐	2 ☐
after prolonged standing?	(028)	1 ☐	2 ☐

l. How old were you when you first experienced this recurring back or neck pain?
(029) 1 ☐ Less than 20 years old
2 ☐ 20 – 29 years old
3 ☐ 30 – 39 years old
4 ☐ 40 – 49 years old
5 ☐ 50 – 59 years old
6 ☐ 60 years old or older

m. When was the last time you had this pain?
(030) 1 ☐ Now
2 ☐ Less than 1 year ago but not now
3 ☐ 1 – 2 years ago
4 ☐ 3 – 5 years ago
5 ☐ 6 years ago or more

n. What is the longest episode of back or neck pain you have ever had?
(031) 1 ☐ Less than one month
2 ☐ One but less than two months
3 ☐ 2 – 3 months
4 ☐ 4 – 5 months
5 ☐ 6 months or more
9 ☐ Don't remember

o. Does this back or neck pain occur more frequently now than it used to occur?
(032) 1 ☐ Yes
2 ☐ No

p. Have you ever had a sprained back due to some type of physical activity?
(033) 1 ☐ Yes
2 ☐ No

q. Have you ever had a "whiplash" injury of the neck?
(034) 1 ☐ Yes
2 ☐ No

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

Question		Code	Response
3c. In which knee did you first have it?	3c.	074	1 ☐ Left knee 2 ☐ Right knee 3 ☐ Both knees 9 ☐ Don't remember
d. How old were you when you first experienced recurring pain in the knee?	d.	075	1 ☐ Less than 20 years old 2 ☐ 20–29 years old 3 ☐ 30–39 years old 4 ☐ 40–49 years old 5 ☐ 50–59 years old 6 ☐ 60 years old or older

e. When this knee pain is present, where is it most intense?	Code	Yes	No
Right knee	076	1 ☐	2 ☐
Left knee	077	1 ☐	2 ☐
Both knees	078	1 ☐	2 ☐
Behind the right knee	079	1 ☐	2 ☐
Behind the left knee	080	1 ☐	2 ☐
Behind both knees	081	1 ☐	2 ☐

Question		Code	Response
f. When this knee pain is present, does it hurt at rest as well as when moving?	f.	082	1 ☐ Yes 2 ☐ No
g. When this knee pain is present, is there also swelling of the knee joint?	g.	083	1 ☐ Yes 2 ☐ No
h. When this pain is present, have you every had "locking" of the knee?	h.	084	1 ☐ Yes 2 ☐ No
i. Has either knee ever "given way" under you?	i.	085	1 ☐ Yes – *Ask j* 2 ☐ No – *SKIP to k*
j. Which knee?	j.	086	1 ☐ Right 2 ☐ Left 3 ☐ Both
k. When was the last time you had this knee pain?	k.	087	1 ☐ Now 2 ☐ Less than 1 year ago but not now 3 ☐ 1–2 years ago 4 ☐ 3–5 years ago 5 ☐ 6 years ago or more
l. What was the longest episode of knee pain you have ever had?	l.	088	1 ☐ Less than one month 2 ☐ One but less than 2 months 3 ☐ 2–3 months 4 ☐ 4–5 months 5 ☐ 6 months or more 9 ☐ Don't remember
m. Have you ever had a fractured knee?	m.	089	1 ☐ Yes – *Ask n* 2 ☐ No – *SKIP to o*
n. Which knee?	n.	090	1 ☐ Right 2 ☐ Left 3 ☐ Both
o. Have you ever had a severe twisting of either knee with resultant sprain or swelling lasting more than two weeks?	o.	091	1 ☐ Yes – *Ask p* 2 ☐ No – *SKIP to q*
p. Which knee?	p.	092	1 ☐ Right 2 ☐ Left 3 ☐ Both
q. Have you ever had any other knee injury?	q.	093	1 ☐ Yes – *Ask r* 2 ☐ No – *SKIP to 4a*
r. Which knee?	r.	094	1 ☐ Right 2 ☐ Left 3 ☐ Both
4a. Have you ever had hip, knee, or back disease treated by an operation?	4a.	095	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 5a*
b. Which joint?	b.	096	1 ☐ Hip 2 ☐ Knee 3 ☐ Back 4 ☐ Hip and knee 5 ☐ Back and knee 6 ☐ Hip and back 7 ☐ ALL
IF HIP: (1) Which hip?	(1)	097	1 ☐ Right 2 ☐ Left 3 ☐ Both
IF KNEE: (2) Which knee?	(2)	098	1 ☐ Right 2 ☐ Left 3 ☐ Both
c. What was the operation or procedure? *Specify* ______________________			
5a. Have you had pain or aching in any joint other than the hip, back, or knee on most days for at least six weeks?	5a.	099	1 ☐ Yes – *Ask b and c* 2 ☐ No – *SKIP to 6a*

b. Which joints were painful? (b. & c.)	Code	Yes	No	5c. *If "Yes,"* – Which? Code	Right	Left	Both
Fingers	100	1 ☐	2 ☐	101	1 ☐	2 ☐	3 ☐
Wrist	102	1 ☐	2 ☐	103	1 ☐	2 ☐	3 ☐
Elbow	104	1 ☐	2 ☐	105	1 ☐	2 ☐	3 ☐
Shoulder	106	1 ☐	2 ☐	107	1 ☐	2 ☐	3 ☐
Ankle	108	1 ☐	2 ☐	109	1 ☐	2 ☐	3 ☐
Foot	110	1 ☐	2 ☐	111	1 ☐	2 ☐	3 ☐

Question		Code	Response
6a. Have you ever had any swelling of joints with pain present when the joint was touched on most days for at least one month?	6a.	112	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 7a*
b. Has this swelling been present on any one occasion for at least six weeks?	b.	113	1 ☐ Yes 2 ☐ No

6c. Which joints are usually involved whenever you have this swelling and tenderness on touching? 6c. & d.	Yes	No	6d. If "Yes," – Which? Right	Left	Both
Fingers	(114) 1 ☐	2 ☐	(115) 1 ☐	2 ☐	3 ☐
Wrists	(116) 1 ☐	2 ☐	(117) 1 ☐	2 ☐	3 ☐
Elbows	(118) 1 ☐	2 ☐	(119) 1 ☐	2 ☐	3 ☐
Shoulders	(120) 1 ☐	2 ☐	(121) 1 ☐	2 ☐	3 ☐
Hips	(122) 1 ☐	2 ☐	(123) 1 ☐	2 ☐	3 ☐
Knees	(124) 1 ☐	2 ☐	(125) 1 ☐	2 ☐	3 ☐
Ankles	(126) 1 ☐	2 ☐	(127) 1 ☐	2 ☐	3 ☐
Feet	(128) 1 ☐	2 ☐	(129) 1 ☐	2 ☐	3 ☐

6e. How old were you when you first experienced this swelling of the joints? **e.**

(130) 1 ☐ Less than 20 years old
2 ☐ 20 – 29 years old
3 ☐ 30 – 39 years old
4 ☐ 40 – 49 years old
5 ☐ 50 – 59 years old
6 ☐ 60 years old or older

f. When was the last time you had this? **f.**

(131) 1 ☐ Now
2 ☐ Less than 1 year ago but not now
3 ☐ 1 – 2 years ago
4 ☐ 3 – 5 years ago
5 ☐ 6 years ago or more

7a. Have you had stiffness in your joints and muscles when first getting out of bed in the morning on most mornings for at least one month? **7a.**

(132) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 8a*

b. Has this morning stiffness been present on any one occasion for at least six weeks? **b.**

(133) 1 ☐ Yes
2 ☐ No

c. Which joints are usually involved whenever you have this morning stiffness? c. & d.	Yes	No	7d. If "Yes," – Which? Right	Left	Both
Fingers	(134) 1 ☐	2 ☐	(135) 1 ☐	2 ☐	3 ☐
Wrists	(136) 1 ☐	2 ☐	(137) 1 ☐	2 ☐	3 ☐
Elbows	(138) 1 ☐	2 ☐	(139) 1 ☐	2 ☐	3 ☐
Shoulders	(140) 1 ☐	2 ☐	(141) 1 ☐	2 ☐	3 ☐
Hips	(142) 1 ☐	2 ☐	(143) 1 ☐	2 ☐	3 ☐
Knees	(144) 1 ☐	2 ☐	(145) 1 ☐	2 ☐	3 ☐
Ankles	(146) 1 ☐	2 ☐	(147) 1 ☐	2 ☐	3 ☐
Feet	(148) 1 ☐	2 ☐	(149) 1 ☐	2 ☐	3 ☐
Back	(150) 1 ☐	2 ☐			

e. How long after getting up and moving around does the morning stiffness last? **e.**

(152) 1 ☐ Less than 15 minutes
2 ☐ 15 minutes to one half hour
3 ☐ More than one half hour but less than all day
4 ☐ All day

f. How old were you when you first experienced this morning stiffness of joints? **f.**

(153) 1 ☐ Less than 20 years old
2 ☐ 20 – 29 years old
3 ☐ 30 – 39 years old
4 ☐ 40 – 49 years old
5 ☐ 50 – 59 years old
6 ☐ 60 years old or older

g. When was the last time you had this? **g.**

(154) 1 ☐ Now
2 ☐ Less than 1 year ago but not now
3 ☐ 1 – 3 years ago
4 ☐ 4 – 9 years ago
5 ☐ 10 years ago or more

8a. Have you ever had pain, swelling, or stiffness in a joint as the result of an accident or injury? **8a.**

(155) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 9*

b. Was this the cause of the pain, swelling, or stiffness mentioned previously, do you think? **b.**

(156) 1 ☐ Yes
2 ☐ No
9 ☐ Don't know

c. Is this the cause of any pain, swelling, or stiffness which might still be present, do you think? **c.**

(157) 1 ☐ Yes
2 ☐ No
9 ☐ Don't know

9. Have you ever been treated by any of the following people for your joint troubles? 9.		Yes	No
General practitioner	(158)	1 ☐	2 ☐
Internist	(159)	1 ☐	2 ☐
Rheumatologist	(160)	1 ☐	2 ☐
Orthopedist	(161)	1 ☐	2 ☐
Chiropractor	(162)	1 ☐	2 ☐
Osteopath	(163)	1 ☐	2 ☐
Foot doctor (chiropodist or podiatrist)	(164)	1 ☐	2 ☐
Physical therapist	(165)	1 ☐	2 ☐
Occupational therapist	(166)	1 ☐	2 ☐
Other – *Specify* ________	(167)	1 ☐	2 ☐
Never been treated	(168)	3 ☐ *SKIP to 11a*	

10a. Are you currently being treated by a doctor for the troubles you have just described?

10a. (169) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 11a*

b. What type of doctor is he?

b. (170) 1 ☐ General practitioner
2 ☐ Internist
3 ☐ Rheumatologist
4 ☐ Orthopedist
5 ☐ Chiropractor
6 ☐ Osteopath
7 ☐ Other specialist
8 ☐ Other – *Specify* ______

c. What did he say the problem was?

______

______

______

c. *DATA PREPARATION USE ONLY*

(171) 1 ☐ (174) 1 ☐
(172) 1 ☐ (175) 1 ☐
(173) 1 ☐ (176) 1 ☐

d. When was the last time you saw him?

d. (177) 1 ☐ Less than 1 month ago
2 ☐ 1 – 3 months ago
3 ☐ 4 – 6 months ago
4 ☐ 7 – 11 months ago
5 ☐ 1 year ago or more
6 ☐ Don't know

e. Who originally referred you to this doctor?

e. (178) 1 ☐ No one
2 ☐ He's the regular doctor
3 ☐ Another doctor
4 ☐ Family
5 ☐ Clinic
6 ☐ Health nurse
7 ☐ Friend
8 ☐ Other – *Specify* ______

f. Where do you usually see him?

f. (179) 1 ☐ His office
2 ☐ At a clinic
3 ☐ At home
4 ☐ Other

g. How long will it be until your next visit to him?

g. (180) 1 ☐ Less than 1 month
2 ☐ 1 – 2 months
3 ☐ 3 – 6 months
4 ☐ 7 – 11 months
5 ☐ 1 year or more
6 ☐ Don't know

11a. Have you ever used any of the following kinds of treatment for your joint troubles?

11b. Did it do you any good?

	11a.	Yes	No	11b.	Yes	No
Splints or casts	(181)	1 ☐	2 ☐	(182)	1 ☐	2 ☐
Braces	(183)	1 ☐	2 ☐	(184)	1 ☐	2 ☐
Diathermy or paraffin	(185)	1 ☐	2 ☐	(186)	1 ☐	2 ☐
Hot packs or heating pads	(187)	1 ☐	2 ☐	(188)	1 ☐	2 ☐
Cold packs or ice	(189)	1 ☐	2 ☐	(190)	1 ☐	2 ☐
Rest	(191)	1 ☐	2 ☐	(192)	1 ☐	2 ☐
Traction	(193)	1 ☐	2 ☐	(194)	1 ☐	2 ☐
Exercises or physical therapy	(195)	1 ☐	2 ☐	(196)	1 ☐	2 ☐
Aspirin	(197)	1 ☐	2 ☐	(198)	1 ☐	2 ☐
Cane	(199)	1 ☐	2 ☐	(200)	1 ☐	2 ☐
Crutch	(201)	1 ☐	2 ☐	(202)	1 ☐	2 ☐
Stiff mattress	(203)	1 ☐	2 ☐	(204)	1 ☐	2 ☐
Bed board	(205)	1 ☐	2 ☐	(206)	1 ☐	2 ☐

c. *If "Yes" to 11a or 11b* – Do you use it regularly?

	c.	Yes	No
Splints or casts	(207)	1 ☐	2 ☐
Braces	(208)	1 ☐	2 ☐
Diathermy or paraffin	(209)	1 ☐	2 ☐
Hot packs or heating pads	(210)	1 ☐	2 ☐
Cold packs or ice	(211)	1 ☐	2 ☐
Rest	(212)	1 ☐	2 ☐
Traction	(213)	1 ☐	2 ☐
Exercises or physical therapy	(214)	1 ☐	2 ☐
Aspirin	(215)	1 ☐	2 ☐
Cane	(216)	1 ☐	2 ☐
Crutch	(217)	1 ☐	2 ☐
Stiff mattress	(218)	1 ☐	2 ☐
Bed board	(219)	1 ☐	2 ☐

12a. Have you ever had injections into any of your joints?

12a. (220) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 13a*

b. *Did they do you any good?*

b. (221) 1 ☐ Yes
2 ☐ No

13a. Have you ever taken any of the following medications for your joints?

		Yes	No	Don't know
Any cortisone-like medicine by mouth	(222)	1 ☐	2 ☐	9 ☐
Butazolidin	(223)	1 ☐	2 ☐	9 ☐
Darvon or Tylenol	(224)	1 ☐	2 ☐	9 ☐
Indocin	(225)	1 ☐	2 ☐	9 ☐

b. *If "Yes"* – Did it do any good?

		Yes	No
Any cortisone-like medicine by mouth	(226)	1 ☐	2 ☐
Butazolidin	(227)	1 ☐	2 ☐
Darvon or Tylenol	(228)	1 ☐	2 ☐
Indocin	(229)	1 ☐	2 ☐

14. Can you do the following things without the help of someone else or the help of some special device?

		Yes	No
Go up or down stairs	(230)	1 ☐	2 ☐
Get into or out of a car	(231)	1 ☐	2 ☐
Use washing facilities	(232)	1 ☐	2 ☐
Dress yourself	(233)	1 ☐	2 ☐
Feed yourself	(234)	1 ☐	2 ☐
Get into or out of bed	(235)	1 ☐	2 ☐

15. At the present time, does your joint condition restrict your physical activity very little, quite a bit, or a whole lot?

(236) 1 ☐ Very little
2 ☐ Quite a bit
3 ☐ A whole lot

16. Have you ever had to stay in bed at home for long periods of time because of your joints?

(237) 1 ☐ Yes
2 ☐ No

17. Have you ever stayed overnight in a hospital because of joint problems?

(238) 1 ☐ Yes
2 ☐ No

18. With respect to your joint trouble, would you say your condition is mild, moderate, or severe?

(239) 1 ☐ Mild
2 ☐ Moderate
3 ☐ Severe

19. What was your job status one month before you first developed your joint condition?

(240) 1 ☐ Retired because of age
2 ☐ Retired because of disability
3 ☐ Unemployed
4 ☐ Working full-time
5 ☐ Working part-time
6 ☐ Housewife with full duties
7 ☐ Housewife with partial or no duties
8 ☐ Other – *Specify*

20a. As a result of your joint condition, has there been a change in your job status?

(241) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 21*

b. What is it now?

(242) 1 ☐ Retired because of disability
2 ☐ Unemployed
3 ☐ Changed to easier job
4 ☐ Working
5 ☐ Housewife with partial duties
6 ☐ Housewife with no duties
7 ☐ Other – *Specify*

21. How many work days do you estimate that you lost during the past 12 months as a result of your joint condition?

(243) 1 ☐ None
2 ☐ 1 – 4 days
3 ☐ 5 – 9 days
4 ☐ 10 – 14 days
5 ☐ 15 – 19 days
6 ☐ 20 – 29 days
7 ☐ 30 days or more

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

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

SUPPLEMENT B – RESPIRATORY

a. Name (Last, first, middle)

b. Deck No. 131

c. Sample No. _ _ _ _ _

READ – Earlier you mentioned having had either persistent cough, phlegm, wheezing, shortness of breath, asthma, or hay fever. Here are some additional questions about this trouble.

PERSISTENT COUGHING

1a. Was your problem that of persistent coughing?
(001) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 2a*

b. How long have you had this condition?
(002) 1 ☐ Less than 1 year
2 ☐ 1–3 years
3 ☐ 4–9 years
4 ☐ 10 years or more

c. Have you been bothered by this within the past year?
(003) 1 ☐ Yes
2 ☐ No

d. When you have this trouble, do you also have chest pains?
(004) 1 ☐ Yes – *Ask e*
2 ☐ No – *SKIP to f*

e. Where?

	Code	Yes	No
Upper back	(005)	1 ☐	2 ☐
Lower back	(006)	1 ☐	2 ☐
Upper chest	(007)	1 ☐	2 ☐
Along the rib edge	(008)	1 ☐	2 ☐
On the sides	(009)	1 ☐	2 ☐

f. Do you bring up phelgm with the cough?
(010) 1 ☐ Yes
2 ☐ No

g. Do you cough persistently like this on most days for as much as THREE months each year?
(011) 1 ☐ Yes
2 ☐ No

h. Do any medicines you take help relieve the cough?
(012) 1 ☐ Yes
2 ☐ No

i. What time of year do these coughing attacks seem at their worst?
(013) 1 ☐ Winter
2 ☐ Summer
3 ☐ No difference

2a. Have you had trouble with coughing spells when you first get up in the early morning? (Count a cough with first smoke or on first going out of doors; exclude clearing of throat or a single cough.)
(014) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 3a*

b. How long have you had this particular condition?
(015) 1 ☐ Less than 1 year
2 ☐ 1–3 years
3 ☐ 4–9 years
4 ☐ 10 years or more
9 ☐ Don't know

c. Do you have chest pains when you have morning coughing spells?
(016) 1 ☐ Yes – *Ask d*
2 ☐ No – *SKIP to e*

d. Where?

	Code	Yes	No
Upper back	(017)	1 ☐	2 ☐
Lower back	(018)	1 ☐	2 ☐
Upper chest	(019)	1 ☐	2 ☐
Along the rib edge	(020)	1 ☐	2 ☐
On the sides	(021)	1 ☐	2 ☐

e. What time of year are these morning coughing spells at their worst?
(022) 1 ☐ Winter
2 ☐ Summer
3 ☐ No difference

f. Do you have a morning cough like this on most days for as much as THREE months each year?
(023) 1 ☐ Yes
2 ☐ No

g. Do you usually have a persistent cough at other times during the day or at night in the winter? (IGNORE AN OCCASIONAL COUGH.)
(024) 1 ☐ Yes
2 ☐ No

h. Do you usually have a persistent cough at other times during the day or at night in the summer? (IGNORE AN OCCASIONAL COUGH.)
(025) 1 ☐ Yes
2 ☐ No

PHLEGM

3a. Do you usually bring up any phlegm from your chest first thing in the morning? (Count phelgm with the first smoke or on going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.)
(026) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 4a*

b. How long have you had this condition?
(027) 1 ☐ Less than 1 year
2 ☐ 1–3 years
3 ☐ 4–9 years
4 ☐ 10 years or more
9 ☐ Don't know

Question		Code	Yes	No
c. What color is the phlegm?	c.		Yes	No
Green		028	1 ☐	2 ☐
Yellow		029	1 ☐	2 ☐
Clear		030	1 ☐	2 ☐
Blood-streaked		031	1 ☐	2 ☐

d. Do you also bring up any phlegm from your chest at other times during the day or at night, in the winter? *(At least two times or more)* — d. (032) 1 ☐ Yes 2 ☐ No

e. Do you also bring up any phlegm from your chest during the day, or at night, in the summer? *(At least two times or more)* — e. (033) 1 ☐ Yes 2 ☐ No

f. What time of year do you seem to bring up the most phlegm from your chest? — f. (034) 1 ☐ Winter 2 ☐ Summer 3 ☐ No difference

g. If you have brought up phlegm, do you bring it up on most days for as much as THREE months each year? — g. (035) 1 ☐ Yes 2 ☐ No

▶ SHORTNESS OF BREATH

4a. Have you had shortness of breath either when hurrying on the level or walking up a slight hill? — 4a. (036) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 5a*

b. Have you had this problem most days for as much as THREE months each year? — b. (037) 1 ☐ Yes 2 ☐ No

c. Do you get short of breath when walking with other people at an ordinary pace on the level? — c. (038) 1 ☐ Yes 2 ☐ No

d. Do you have to stop for breath when walking at your own pace on the level? — d. (039) 1 ☐ Yes 2 ☐ No

e. Do you have to stop for breath after walking about 100 yards or after a few minutes on the level? — e. (040) 1 ☐ Yes 2 ☐ No

f. How long ago did you first have this trouble with shortness of breath? — f. (041) 1 ☐ Less than 1 year ago 2 ☐ 1–3 years ago 3 ☐ 4–9 years ago 4 ☐ 10 years ago or more 9 ☐ Don't know

g. Have you gotten chest pains along with the shortness of breath? — g. (042) 1 ☐ Yes – *Ask h* 2 ☐ No – *SKIP to i*

Question		Code	Yes	No
h. Where?	h.		Yes	No
Upper chest		043	1 ☐	2 ☐
Upper back		044	1 ☐	2 ☐
Lower back		045	1 ☐	2 ☐
Along the lower ribs		046	1 ☐	2 ☐
On the sides		047	1 ☐	2 ☐

i. Do you develop wheezing as well as shortness of breath? — i. (048) 1 ☐ Yes 2 ☐ No

j. Have you ever felt like you were going to pass out from the shortness of breath? — j. (049) 1 ☐ Yes 2 ☐ No

▶ WHEEZING

5a. Has your chest ever sounded wheezy or whistling? — 5a. (050) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 6a*

b. How long have you had this condition? — b (051) 1 ☐ Less than 1 year 2 ☐ 1–3 years 3 ☐ 4–9 years 4 ☐ 10 years or more

c. Do you get this wheezing or whistling with colds? — c. (052) 1 ☐ Yes 2 ☐ No

d. Do you get this occasionally apart from colds? — d. (053) 1 ☐ Yes 2 ☐ No

e. Does this usually occur daily? — e. (054) 1 ☐ Yes 2 ☐ No

f. What time of year does it seem worst? — f. (055) 1 ☐ Winter 2 ☐ Summer 3 ☐ No difference

g. Is this wheeziness present on most days for as much as THREE months each year? — g (056) 1 ☐ Yes 2 ☐ No

h. Do you take any medicines for wheezing? — h. (057) 1 ☐ Yes – *Ask i* 2 ☐ No – *SKIP to 6a*

i. Do they help relieve the wheezing? — i. (058) 1 ☐ Not at all 2 ☐ A small amount 3 ☐ A great deal

▶ ASTHMA

6a. Have you had, or do you now have asthma? — 6a. (059) 1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 7a*

Question		Code	Yes	No
b. What is it related to or due to?	b		Yes	No
Dust		060	1 ☐	2 ☐
Foods		061	1 ☐	2 ☐
Animal contacts		062	1 ☐	2 ☐
Drugs		063	1 ☐	2 ☐
Pollens		064	1 ☐	2 ☐
Molds		065	1 ☐	2 ☐
Other – *Specify* ______		066	1 ☐	2 ☐
Don't know		067	9 ☐	

Question		Item	Response
6c. How long have you had this condition?	6c.	068	1 ☐ Less than 1 year – *SKIP to e* 2 ☐ 1–3 years – *SKIP to e* 3 ☐ 4–9 years ago – *SKIP to e* 4 ☐ 10 years or more – *Go to d*
d. Since you were a child?	d.	069	1 ☐ Yes 2 ☐ No
e. Do you have asthma symptoms on most days for as much as THREE months each year?	e.	070	1 ☐ Yes 2 ☐ No
f. What time of year is it worst?	f.		Yes / No
Spring		071	1 ☐ 2 ☐
Summer		072	1 ☐ 2 ☐
Fall		073	1 ☐ 2 ☐
Winter		074	1 ☐ 2 ☐
g. Do you take any medicines for it?	g.	075	1 ☐ Yes 2 ☐ No
▶ HAYFEVER 7a. Have you had, or do you now have, hayfever?	7a.	076	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 8a*
b. What is it related to or due to?	b.		Yes / No
Dust		077	1 ☐ 2 ☐
Foods		078	1 ☐ 2 ☐
Animal contacts		079	1 ☐ 2 ☐
Drugs		080	1 ☐ 2 ☐
Pollens		081	1 ☐ 2 ☐
Molds		082	1 ☐ 2 ☐
Air conditioners		083	1 ☐ 2 ☐
Other – *Specify* ______		084	1 ☐ 2 ☐
Don't know		085	9 ☐
c. How long have you had this condition?	c.	086	1 ☐ Less than 1 year – *SKIP to e* 2 ☐ 1–3 years – *SKIP to e* 3 ☐ 4–9 years – *SKIP to e* 4 ☐ 10 years or more – *Ask d*
d. Since you were a child?	d.	087	1 ☐ Yes 2 ☐ No
7e. Do you have hayfever symptoms on most days for as much as THREE months each year?	7e.	088	1 ☐ Yes 2 ☐ No
f. What time of the year is it worst?	f.		Yes / No
Spring		089	1 ☐ 2 ☐
Summer		090	1 ☐ 2 ☐
Fall		091	1 ☐ 2 ☐
Winter		092	1 ☐ 2 ☐
g. Do you take any medicines for it?	g.	093	1 ☐ Yes 2 ☐ No
▶ MEDICAL CARE 8a. Have you ever been tested for TB (tuberculosis)?	8a.	094	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 9a*
b. How were you tested?	b.		Yes / No
A skin test		095	1 ☐ 2 ☐
Chest x-ray		096	1 ☐ 2 ☐
Sputum examination		097	1 ☐ 2 ☐
Don't know		098	9 ☐
c. How often are you tested?	c.	099	1 ☐ Once every year 2 ☐ Once every two years 3 ☐ Once every 3–5 years 4 ☐ Less often than once every 5 years
d. How long ago were you last tested?	d.	100	1 ☐ Less than 1 year ago 2 ☐ 1–2 years ago 3 ☐ 3–5 years ago 4 ☐ 6–9 years ago 5 ☐ 10 years ago or more 9 ☐ Don't know
9a. Have you seen a doctor or anyone else about the chest or lung conditions you mentioned previously?	9a.	101	1 ☐ Yes – *Ask b* 2 ☐ No – *SKIP to 10*
b. What is the name of the doctor you see? ______			
c. What type of doctor is he?	c.	102	1 ☐ General Practitioner 2 ☐ Internist 3 ☐ Osteopath 4 ☐ Surgeon 5 ☐ Lung specialist 6 ☐ Allergist 7 ☐ Other – *Specify* ______
d. Who initially referred you to this doctor?	d.	103	1 ☐ No one 2 ☐ He's the regular doctor 3 ☐ Another physician 4 ☐ Health nurse 5 ☐ Clinic 6 ☐ Family 7 ☐ Other – *Specify* ______

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

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

SUPPLEMENT C – CARDIOVASCULAR

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

a. Name (Last, first, middle)	b. Deck No.	c. Sample No.
	141	_ _ _ _ _

READ – **Earlier you mentioned having a history of either chest pains, chest discomfort or heaviness, leg pains while walking, or heart failure. Here are some additional questions about it.**

1a. Was the problem that of chest pains, chest discomfort, pressure, or heaviness?
(001) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 2a*

b. How would you best describe this pain or discomfort?

		Yes	No
Heaviness	(002)	1 ☐	2 ☐
Burning sensation	(003)	1 ☐	2 ☐
Tightness	(004)	1 ☐	2 ☐
Stabbing pain	(005)	1 ☐	2 ☐
Pressure	(006)	1 ☐	2 ☐
Sharp pain	(007)	1 ☐	2 ☐
Shooting pains	(008)	1 ☐	2 ☐

c. Have you had it more than THREE times?
(009) 1 ☐ Yes 2 ☐ No

d. Have you been bothered by this within the past 12 months?
(010) 1 ☐ Yes 2 ☐ No

e. How old were you when you first had it?
(011) 1 ☐ 10 – 19 years old 4 ☐ 40 – 49 years old
2 ☐ 20 – 29 years old 5 ☐ 50 – 59 years old
3 ☐ 30 – 39 years old 6 ☐ 60 years old or older

f. Do you get it if you walk at an ordinary pace on level ground?
(012) 1 ☐ Yes 2 ☐ No

g. Do you get it if you walk uphill or hurry?
(013) 1 ☐ Yes – *Ask h*
2 ☐ No – *SKIP to k*

1h. What do you do if you get it while walking?

		Yes	No
Stop	(014)	1 ☐	2 ☐
Slow down	(015)	1 ☐	2 ☐
Continue at same pace	(016)	1 ☐	2 ☐
Take medicine	(017)	1 ☐	2 ☐

i. If you do stop or slow down, is it relieved or not?
(018) 1 ☐ Relieved – *Ask j*
2 ☐ Not relieved – *SKIP to k*

j. How soon?
(019) 1 ☐ Less than 10 minutes
2 ☐ 10 minutes or more

k. When you get pain or discomfort, where is it located?

		Yes	No
Upper middle chest	(020)	1 ☐	2 ☐
Lower middle chest	(021)	1 ☐	2 ☐
Left side of chest	(022)	1 ☐	2 ☐
Left arm	(023)	1 ☐	2 ☐
Right side of chest	(024)	1 ☐	2 ☐
Other – *Specify* ______	(025)	1 ☐	2 ☐

l. Do any of these things tend to bring it on?

		Yes	No
Excitement or emotion	(026)	1 ☐	2 ☐
Stooping over	(027)	1 ☐	2 ☐
Eating a heavy meal	(028)	1 ☐	2 ☐
Coughing spells	(029)	1 ☐	2 ☐
Cold wind	(030)	1 ☐	2 ☐
Exertion	(031)	1 ☐	2 ☐

2a. Have you ever had severe pain across the front of your chest lasting for half an hour or more?
(032) 1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 3a*

b. How many of these attacks have you had?
(033) 1 ☐ One
2 ☐ 2 – 3
3 ☐ 4 or more

c. What was the date of your last attack?
(034) Month __ Year __

d. What was the duration of the pain during your last attack?
(035) 1 ☐ 30 – 59 minutes 5 ☐ 12 – 23 hours
2 ☐ 1 – 2 hours 6 ☐ 24 – 47 hours
3 ☐ 3 – 5 hours 7 ☐ 2 days or more
4 ☐ 6 – 11 hours

e. Did you see a doctor about this last attack?
(036) 1 ☐ Yes – *Ask f*
2 ☐ No – *SKIP to 3a*

f. What did he say it was?
______
______
______
______

DATA PREPARATION USE ONLY
(037) 1 ☐ (041) 1 ☐
(038) 1 ☐ (042) 1 ☐
(039) 1 ☐ (043) 1 ☐
(040) 1 ☐ (044) 1 ☐

3a. Do you get pain or discomfort in either leg while walking? — 3a. (045)
1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 4a*

b. Do you also get this pain in your legs while standing still? — b. (046)
1 ☐ Yes
2 ☐ No

c. In what parts of your leg do you feel this pain? — c. (047)
1 ☐ Lower part (calf)
2 ☐ Upper part (thigh)
3 ☐ Both lower and upper parts

d. Do you get the pain in your legs while quiet or while sitting? — d. (048)
1 ☐ Yes
2 ☐ No

e. Do you get it when you walk up a hill in a hurry? — e. (049)
1 ☐ Yes
2 ☐ No

f. Do you get it when you walk at an ordinary pace on level ground? — f. (050)
1 ☐ Yes
2 ☐ No

g. Does the pain in your legs come on after you have taken a few steps? — g. (051)
1 ☐ Yes
2 ☐ No

h. Does the pain disappear while you are still walking? — h. (052)
1 ☐ Yes
2 ☐ No

i. What do you do when you get it while you are walking? — i.

		Yes	No
Stop	(053)	1 ☐	2 ☐
Slow down	(054)	1 ☐	2 ☐
Continue at same pace	(055)	1 ☐	2 ☐
Take medicine	(056)	1 ☐	2 ☐

j. If you stop, is it relieved or not? — j. (057)
1 ☐ Relieved – *Ask k*
2 ☐ Not relieved – *SKIP to l*

k. How soon after stopping? — k. (058)
1 ☐ Less than 10 minutes
2 ☐ 10 minutes or more

l. Is the pain more likely to occur when you are hurrying than when you are walking at a slower, more even pace? — l. (059)
1 ☐ Yes
2 ☐ No

4a. Have you ever seen a doctor about chest pains, chest discomfort, pains in the legs while walking, or heart failure? — 4a. (060)
1 ☐ Yes – *Ask b*
2 ☐ No – *SKIP to 5*

b. What is the name of the doctor?

____

c. What type of doctor is he? — c. (061)
1 ☐ General practitioner
2 ☐ Osteopath
3 ☐ Heart specialist
4 ☐ Other specialist
5 ☐ Other – *Specify* ________
9 ☐ Don't know

d. Who initially referred you to this doctor? — d.

		Yes	No
No one	(062)	1 ☐	2 ☐
He's the regular doctor	(063)	1 ☐	2 ☐
Another doctor	(064)	1 ☐	2 ☐
Family	(065)	1 ☐	2 ☐
Clinic	(066)	1 ☐	2 ☐
Health nurse	(067)	1 ☐	2 ☐
Other – *Specify* ________	(068)	1 ☐	2 ☐

e. How long after this trouble first started did you first visit your doctor about it? — e. (069)
1 ☐ Less than 1 day
2 ☐ 1 – 2 days
3 ☐ 3 – 6 days
4 ☐ 1 – 3 weeks
5 ☐ 1 – 5 months
6 ☐ 6 – 11 months
7 ☐ 1 year or more
9 ☐ Don't remember

f. At that time, what did he say the problem was?

____

g. Did you have a cardiogram at the first visit? — g. (070)
1 ☐ Yes
2 ☐ No

h. Did you have one at a later visit? — h. (071)
1 ☐ Yes – *Ask i*
2 ☐ No – *SKIP to 4j*

i. How long was it from the time of the first visit? — i. (072)
1 ☐ 1 – 2 days
2 ☐ 3 – 6 days
3 ☐ 1 – 3 weeks
4 ☐ 1 – 5 months
5 ☐ 6 – 11 months
6 ☐ 1 year or more
9 ☐ Don't know

j. Did you have a chest X-ray at the first visit? — j. (073)
1 ☐ Yes
2 ☐ No

k. Did you have one at a later visit? — k. (074)
1 ☐ Yes – *Ask l*
2 ☐ No – *SKIP to m*

l. How long was it from the time of the first visit? — l. (075)
1 ☐ 1 – 2 days
2 ☐ 3 – 6 days
3 ☐ 1 – 3 weeks
4 ☐ 1 – 5 months
5 ☐ 6 – 11 months
6 ☐ 1 year or more
9 ☐ Don't know

m. Have you had any other tests for this condition? (such as blood or urine) — m. (076)
1 ☐ Yes
2 ☐ No

n. Did the doctor prescribe medicines to take for your condition? — n. (077)
1 ☐ Yes – *Ask o*
2 ☐ No – *SKIP to p*

o. How do you take the medicine? — o.

		Yes	No
Swallowed	(078)	1 ☐	2 ☐
Under the tongue	(079)	1 ☐	2 ☐
Injected	(080)	1 ☐	2 ☐
Other – *Specify* ________	(081)	1 ☐	2 ☐

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

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

CONTROL RECORD[1]

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

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

a. Name (Last, first, middle)	b. Deck No. 211	c. Sex 1 ☐ Male 2 ☐ Female

d. Date of birth Month	Day	Year	e. Age	f. Examination date Month (001)	Day	Year	g. Temperature (002) ___.__

PROCEDURE	TIME IN	TIME OUT	NOT DONE	STAFF	Procedure or part of overall procedure not done (Enter reason for non-completion)
1. Casual specimen	(003)	(004)	x ☐		
2. Body measurements	(005)	(006)	x ☐		
3. Physician's examination	(007)	(008)	x ☐		
4. Venipuncture	(009)	(010)	x ☐		
5. Dental examination	(011)	(012)	x ☐		
6. Dermatology examination	(013)	(014)	x ☐		
7. Ophthalmology I	(015)	(016)	x ☐		
8. Ophthalmology II	(017)	(018)	x ☐		
9. Nutrition questionnaire	(019)	(020)	x ☐		
	(021) 1 ☐ In home	2 ☐ Not in home			
10. Hand and wrist X-ray (Ages 1–17)	(022)	(023)	x ☐		

OFFICE USE ONLY	Time in	Time out	Sample Number
(061) N ☐ (071) N ☐ (081) N ☐			

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

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

Form Approved
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GENERAL MEDICAL EXAMINATION – AGES 1–74

a. Name (Last, first, middle)	b. Deck No.	c. Pulse	d. Blood pressure (over 6 years)	
	231	(001) ___	SYSTOLIC (002) ___	DIASTOLIC (003) ___

1. HEAD, EYES, EARS, NOSE, AND THROAT: (004) 1 ☐ Findings 2 ☐ No findings

If findings, mark applicable box and continue with a. If no findings, SKIP to 2a.

Yes

- a. Dry, staring hair (005) 1 ☐
- b. Dyspigmented hair (006) 1 ☐
- c. Easily pluckable hair (007) 1 ☐
- d. Abnormal texture or loss of curl (008) 1 ☐
- e. Circumcorneal injection (009) 1 ☐
- f. Conjunctival injection (010) 1 ☐
- g. Angular blepharitis (011) 1 ☐
- h. Xerosis (012) 1 ☐
- i. Bitot's spots (013) 1 ☐
- j. Keratomalacia (014) 1 ☐
- k. Xerophthalmia (015) 1 ☐
- l. Angular lesions of lips (016) 1 ☐
- m. Angular scars of lips (017) 1 ☐
- n. Cheilosis (018) 1 ☐
- o. Filiform papillary atrophy of tongue (019) 1 ☐
- p. Fungiform papillary hypertrophy of tongue (020) 1 ☐
- q. Geographic tongue (021) 1 ☐
- r. Fissures of tongue (022) 1 ☐
- s. Serrations or swelling of tongue (023) 1 ☐
- t. Scarlet beefy tongue (024) 1 ☐
- u. Magenta tongue (025) 1 ☐
- v. Naso-labial seborrhea (026) 1 ☐
- w. Visible enlarged parotids (027) 1 ☐
- x. Bossing of skull (028) 1 ☐
- y. Other – Specify ______ (029) 1 ☐

2a. THYROID EVALUATION: (WHO Classification) (030) 1 ☐ Group 0 2 ☐ Group 1 3 ☐ Group 2 4 ☐ Group 3

b. OTHER THYROID FINDINGS: (031) 1 ☐ Findings 2 ☐ No findings (GO TO 3)

		R	L	Both
Tenderness	(032)	1 ☐	2 ☐	3 ☐
Nodule	(033)	1 ☐	2 ☐	3 ☐
Isthmus	(034)	1 ☐		
Other – Describe ______	(035)	1 ☐		

3. CHEST EVALUATION (036) 1 ☐ Findings 2 ☐ No findings

If findings, mark applicable box and continue with a. If no findings, SKIP to 4.

Yes

- a. Beading of ribs (037) 1 ☐
- b. Follicular hyperkeratosis of upper back (038) 1 ☐
- c. Wheezing on auscultation
  - 1. Diffuse (039) 1 ☐
  - 2. Focal (040) 1 ☐
- d. Decreased breath sounds (diffuse) (041) 1 ☐
- e. Other findings – Describe (042) 1 ☐

Sample Number

4. CARDIOVASCULAR EVALUATION: (043) 1 ☐ Findings 2 ☐ No findings

If findings, mark applicable box and continue with a. If no findings, SKIP to 5.

Yes

- a. Cyanosis (044) 1 ☐
- b. Irregular pulse (045) 1 ☐
- c. Cardiac murmur (046) 1 ☐ *(Describe: grade, location, radiation, probable valve involved, etc.)*
- d. Other findings – Describe (047) 1 ☐

5. ABDOMINAL EVALUATION: (048) 1 ☐ Findings 2 ☐ No findings

If findings, mark applicable box and continue with a. If no findings, SKIP to 6.

Yes

- a. Hepatomegaly (049) 1 ☐
- b. Splenomegaly (050) 1 ☐
- c. Uterine enlargement (051) 1 ☐
- d. Umbilical hernia (052) 1 ☐
- e. Pot belly (053) 1 ☐
- f. Mass (es) (054) 1 ☐
  - 1. Area(s) – Enter number(s) (055) ______
  - 2. Other findings – Describe (056) 1 ☐
- g. Surgical scars (057) 1 ☐
  - 1. Area(s) – Enter number(s) (058) ______
  - 2. Other findings – Describe (059) 1 ☐

All persons 25 years old or older

- h. Liver size
  - 1. MCL (060) ___ mm.
  - 2. MSL (061) ___ mm.

Sample Number

6. **MUSCULOSKELETAL EVALUATION:**

If findings, mark applicable box and continue with a. If no findings, SKIP to 7.

(062) 1 ☐ Findings 2 ☐ No findings

	Yes
a. Bowed legs	(063) 1 ☐
b. Knock knees	(064) 1 ☐
c. Epiphysial enlargement, wrists	(065) 1 ☐
d. Other findings – Describe	(066) 1 ☐

7. **NEUROLOGICAL EVALUATION:**

If findings, mark applicable box and continue with a. If no findings, SKIP to 8.

(067) 1 ☐ Findings 2 ☐ No findings

	Yes
a. Absent knee jerks	(068) 1 ☐
b. Absent ankle jerks	(069) 1 ☐
c. Positive Chvostek sign	(070) 1 ☐
d. Apathy	(071) 1 ☐
e. Marked hyperirritability	(072) 1 ☐
f. Other findings – *Describe*	(073) 1 ☐

8. **SKIN EVALUATION:**

If findings, mark applicable box and continue with a. If no findings, SKIP to 9.

(074) 1 ☐ Findings 2 ☐ No findings

a. Follicular hyperkeratosis, arms	(075) 1 ☐
b. Hyperpigmentation, hands and face	(076) 1 ☐
c. Dry or scaling skin	(077) 1 ☐
d. Perifolliculosis	(078) 1 ☐
e. Petechiae – *Describe*	(079) 1 ☐
f. Mosaic skin	(080) 1 ☐
g. Pellagrous dermatitis	(081) 1 ☐
h. Ecchymoses – *Describe*	(082) 1 ☐
i. Other findings – Describe	(083) 1 ☐

9. **GENERAL EVALUATION:**

(Conditions which might affect normal growth and development or affect the evaluation of nutrition, such as mongolism, cerebral palsy, dwarfism, parental neglect indicators, etc.)

If findings, describe below. If no findings, SKIP to 10.

(084) 1 ☐ Findings 2 ☐ No findings

10. **SUMMARY OF FINDINGS:**

a. No findings	(085) 1 ☐
b. Findings relating to nutrition	(086) 1 ☐
(List findings)	
c. Other findings, **NOT** relating to nutrition	(087) 1 ☐
(List findings)	
1.	(088) ___
2.	(089) ___
3.	(090) ___
4.	(091) ___

11. **EXAMINER'S SUBJECTIVE IMPRESSION OF NUTRITIONAL STATUS:**

a. Normal nutrition	(092) 1 ☐
b. Abnormal nutrition	2 ☐

12. Obesity	(093) 1 ☐
No obesity	2 ☐

13. Name of physician	Sample Number

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

BODY MEASUREMENTS[1]

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

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

a. Deck No.	b. Examiner No.	c. Recorder No.
111	__ __	

NOTE Measurement in cm. unless otherwise specified.
Measure left side also if the last digit of examinee's sample number is 3 or 6.

Item		Code		Code	
1. Bitrochanteric breadth	1.	(009)	__ __ . __		
			RIGHT SIDE		LEFT SIDE
2. Elbow breadth	2.	(001)	__ __ . __	(002)	__ __ . __
			RIGHT SIDE		LEFT SIDE
3. Upper arm girth	3.	(003)	__ __ . __	(004)	__ __ . __
Head and chest circumference (1–7 years) 4a. Head	4a.	(011)	__ __ . __		
b. Chest	b.	(012)	__ __ . __		
			RIGHT SIDE		LEFT SIDE
5. Triceps skinfold (mm.)	5.	(005)	__ __ . __	(006)	__ __ . __
			RIGHT SIDE		LEFT SIDE
6. Subscapular skinfold (mm.)	6.	(007)	__ __ . __	(008)	__ __ . __
7. Sitting height	7.	(010)	__ __ . __		
When both sides are measured: 8. Is examinee right or left handed?	8.	(016)	1 ☐ Right handed 2 ☐ Left handed 3 ☐ Uses both hands about the same 4 ☐ Not sure 8 ☐ Not applicable		
9. Weight (lbs.)	9.	(013)	__ __ __ . __ __		
10a. Standing height (cm.)	10a.	(014)	__ __ __ . __		
b. Standing height (inches)			__ __ __/		

NOTES

Sample Number

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

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

DERMATOLOGY EXAMINATION

NAME (Last, First, Middle)	SAMPLE NUMBER	EXAMINER NO.	STATE OR FOREIGN COUNTRY OF LONGEST RESIDENCE
			001 002 Years

OCCUPATIONAL EXPOSURE 003 1☐ Yes 2☐ No

IF YES. (CHECK ALL THAT APPLY)
004 1☐ Chemicals, fumes, or vapors
005 1☐ Oils
006 1☐ Insecticides
007 1☐ Immersion (hands or feet)
008 1☐ Other (SPECIFY)

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

SIGNIFICANT DERMATOLOGICAL DIAGNOSIS FROM THIS EXAMINATION

Clinical Impression	Code	Biopsy	
1.	010	011 1☐ Done 2☐ Not done →	012 1☐ Refused 2☐ Other reason
2.	013	014 1☐ Done 2☐ Not done →	015 1☐ Refused 2☐ Other reason
3.	016	017 1☐ Done 2☐ Not done →	018 1☐ Refused 2☐ Other reason

FINDINGS RELATING TO NUTRITION

SIGNIFICANT DERMATOLOGICAL DIAGNOSIS MADE PREVIOUSLY NOW SUPPRESSED OR IN REMISSION

PHOTOGRAPHY OF SKIN Frame No.
Lesion diagnosis code 019

		Code		Certain	Probable	Doubtful
1.	020		021	1☐	2☐	3☐
2.	022		023	1☐	2☐	3☐

GENERAL APPEARANCE (1 - 3)

1. Hair color (Natural) (CHECK 1 BOX)

025 Age at first graying _ _ years

Previous Hair Color if Gray or White 026

		Previous
024 01☐ Gray 1, 2	→	
02☐ Gray 3, 4	→	
03☐ White		
04☐ Black		04☐
05☐ Dark brown		05☐
06☐ Medium to light brown		06☐
07☐ Chestnut or auburn		07☐
08☐ Red (titian, carrot, etc.)		08☐
09☐ Dark blonde		09☐
10☐ Light blonde		10☐

CHECK "YES OR "NO" FOR EACH
Dyed, tinted or bleached? 027 1☐ Yes 2☐ No
Flag signs? 028 1☐ Yes 2☐ No

2. Eye Color - (CHECK 1 BOX)
029
1☐ Dark brown
2☐ Light brown
3☐ Gray, green, hazel
4☐ Speckled
5☐ Dark blue
6☐ Light blue
7☐ Mismatch
8☐ Other (SPECIFY)

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

3. Skin Texture
031 Surface 1☐ NO FINDINGS
032 1☐ Coarse 2☐ Fine
033 1☐ Oily 2☐ Scaling 3☐ Both
034 1☐ Moist
035 Dry 1☐ Senile 2☐ Winter 3☐ Both 4☐ Atopic Dry
036 1☐ Atrophic 2☐ Thickened
037 1☐ Wrinkled
038 1☐ Other (SPECIFY)

Complexion

Code — Skin Color
Abdomen 039
Forearm 040
041 1☐ Florid 2☐ Pallid
042 1☐ Erythematous 2☐ Sallow

4. PIGMENT ABERRATIONS
Items 4-6 → 043 1☐ NO FINDINGS (GO TO ITEM 7)

Type

044 1☐ Melanin general-hyper
045 1☐ Melanin general-hypo
046 1☐ Melanin general-cosmetically disfiguring

Melanin localized
047 1☐ Face
048 1☐ Body
049 1☐ Extremities
050 1☐ Melanin localized - hyper
051 1☐ Melanin localized - hypo
052 1☐ Melanin localized cosmetically disfigur.

053 1☐ Senile depigmentation
054 1☐ Icterus
055 1☐ Tatoo - artifact
056 1☐ Tatoo - traumatic
2☐ Tatoo - traumatic - cosmetically disfig.

Impression

057 1☐ Addison's disease
058 1☐ Albinism - Total
2☐ Albinism - Partial
059 1☐ Pellagroid pigmentation
060 1☐ Vitiligo - Total
2☐ Vitiligo - Partial
061 1☐ Post inflammatory
062 1☐ Chronically ill (hyper)
063 1☐ Other (SPECIFY)

	Significant Scars	Traumatic	Surgical	Both	Herpes Zoster
064	Hypertrophic	1☐	2☐	3☐	4☐
065	Atrophic	1☐	2☐	3☐	4☐
066	Keloids	1☐	2☐	3☐	4☐

5. NEVI
Pigmented and related lesions > 1 cm.

Diagnosis (Clinical impression)	Total No.	Size of Largest		Face	Scalp and Neck	Both		Extremities	Trunk	Trunk and Extremities
Junctional	067	068	069	1☐	2☐	3☐	070	1☐	2☐	3☐
Hutchinsons fr.	071	072	073	1☐	2☐	3☐	074	1☐	2☐	3☐
Mong. spot	075	076	077	1☐	2☐	3☐	078	1☐	2☐	3☐
Blue nevus	079	080	081	1☐	2☐	3☐	082	1☐	2☐	3☐
Nevus of Ota	083	084	085	1☐	2☐	3☐	086	1☐	2☐	3☐
Cafe au lait	087	088	089	1☐	2☐	3☐	090	1☐	2☐	3☐

Senile Lentigenes 091 1☐ Many (10+)
Ephilides → 092 1☐ Many (10+)

6. Vascular

	Total No.	Size of Largest		Face	Scalp and Neck	Both		Extremities	Trunk	Trunk and Extremities
Araneus	093	X	094	1☐	2☐	3☐	095	1☐	2☐	3☐
Flammeus	096	097	098	1☐	2☐	3☐	099	1☐	2☐	3☐
Vasculosus	100	101	102	1☐	2☐	3☐	103	1☐	2☐	3☐
Cavernous	104	105	106	1☐	2☐	3☐	107	1☐	2☐	3☐
Senile hemangioma	108	X	109	1☐	2☐	3☐	110	1☐	2☐	3☐

VASCULAR CHANGES OTHER THAN NEVI (7 - 10)

ITEMS 7-10 ⟶ [111] 1☐ NO FINDINGS (GO TO ITEM 11)

7. RAYNAUD'S PHENOMENON

Source (CHECK ONE)
[112] 1☐ Observed
2☐ By history
3☐ Both

Location (CHECK ONE)
[114] 1☐ Hands
2☐ Feet
3☐ Both

Duration
[113] __ __ Years

8. VASCULAR CHANGES OTHER THAN NEVI

[115] 1☐ Purpura-senile
Other purpura (CHECK ONE)
[116] 1☐ Traumatic
2☐ Med. induced
3☐ Dis. related
4☐ Idiopathic
5☐ Etiology obscure

[117] 1☐ Coldness
[118] 1☐ Cyanosis
[119] 1☐ Edema
Edema, chronic
[120] 1☐ Persistent
2☐ Recurrent
[121] 1☐ Cutis marmorata

9. ACTINIC DAMAGE ⟶

		Minimal	Moderate	Severe
Overall impression	123	1☐	2☐	3☐
Fine telangiectasia	124	1☐	2☐	3☐
Senile Elastosis	125	1☐	2☐	3☐
Actinic keratoses	126	1☐	2☐	3☐

10. OTHER TELANGIECTASIA

Location
[128] 1☐ Face
2☐ Scalp and neck
3☐ Face, scalp, and neck

[129] 1☐ Extremities
2☐ Trunk
3☐ Trunk and extremities

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

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

11. MISCELLANEOUS LESIONS OF COLOR AND TEXTURE

[139] 1☐ NO FINDINGS (GO TO ITEM 12)

		Few ≤5	Many 5 +
Clavus (feet)	140	1☐	2☐
Seborrheic keratoses			
Face and scalp	141	1☐	2☐
Back and chest	142	1☐	2☐
Nasolabial or other body folds	143	1☐	2☐
Papulosa nigra	144	1☐	2☐
Epithelial tags	145	1☐	2☐
Neurofibromata	146	1☐	2☐
Dermatofibromata	147	1☐	2☐
Epidermal nevi	148	1☐	2☐
Warts-hands	149	1☐	2☐
Warts-feet	150	1☐	2☐
Warts-genital	151	1☐	2☐
Warts-other (SPECIFY)	152	1☐	2☐
Tophi	153	1☐	2☐
Xanthomata	154	1☐	2☐
Acanthosis nigracans	155	1☐	2☐
Lichen striatus	156	1☐	2☐

12. NEOPLASTIC CHANGE

[157] 1☐ NO FINDINGS (GO TO ITEM 13)

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

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

13. ECTODERMAL APPENDAGES

Ectodermal glands ⟶ [187] 1☐ NO FINDINGS (GO TO ITEM 14)

Eccrine

Activity	Location: Forehead	Hands	Feet
Marked	[188] 1☐	[189] 1☐	[190] 1☐
Minimal		2☐	2☐
Dishydrotic		[191] 1☐	[192] 1☐

[193] 1☐ Anhydrotic

Apocrine (post pubertal)

Mammary gland development
[194] 1☐ Absent 3☐ Marked
2☐ Deficient

Fox Fordyce disease
[195] 1☐ Axillary
[196] 1☐ Para-areolar
[197] 1☐ Genital

Sebaceous glands:
Sebum production [198] 1☐ Increased
Inclusion cysts (no.) [199] 1☐ < 4 2☐ ≥ 4
Largest [200] ______ cm. (9 or > code to 9)
Location of cysts : ⟶ [201] 1☐ Chest [202] 1☐ Face
[203] 1☐ Back [204] 1☐ Other (SPECIFY)______

14. NAILS ⟶ [205] 1☐ NO FINDINGS (GO TO ITEM 15)

Fingernails (TOTAL NUMBER) [206] __ __

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

Color	[207] __ __	White;	[208] __ __	yellow;	[209] __ __	Green, brown or black
Quality	[210] __ __	Soft;	[211] __ __	Brittle		
Contour	[212] __ __	Raised;	[213] __ __	Spooned		
Surface	[214] __ __	Ridged;	[215] __ __	Pitted		
Other	[216] __ __	Thickened;	[217] __ __	Clubbed		

Complete absence of nails, not traumatic [218] 1☐
Bands [219] __ __ White, cross; [220] __ __ Pigmented long

Clinical impression of abnormalities noted above:

[221] 1☐ Fungus [222] 1☐ Trauma [223] 1☐ Alopecia areata
[224] 1☐ Lichen planus [225] 1☐ Nevus [226] 1☐ Psoriasis
[227] 1☐ Other (SPECIFY)______

Toenails

Abnormalities

[228] 1☐ Thickened [229] 1☐ Discolored [230] 1☐ Pigmented bands

Clinical impression of abnormalities noted above:

[231] 1☐ Fungus [232] 1☐ Psoriasis [233] 1☐ Nevus
[234] 1☐ Trauma [235] 1☐ Other (SPECIFY)______

15. HAIR ———> [236] 1☐ NO FINDINGS

Scalp: Alopecia

		Min.	Mod.	Severe
Male Pattern	237	1☐	2☐	3☐
Localized	238	1☐	2☐	3☐
Diffuse	239	1☐	2☐	3☐

→ Impression of etiology

[240] 1☐ Areata [241] 1☐ Infection
[242] 1☐ Anti metabolites [243] 1☐ Trauma
[244] 1☐ Postclimacteric [245] 1☐ Familial

Texture:
[246] 1☐ Fine 2☐ Coarse
[247] 1☐ Dry staring 2☐ Easily plucked 3☐ Both

Eyebrows:
[248] 1☐ Sparse 2☐ Absent

Eyelashes:
[249] 1☐ Sparse 2☐ Absent

Facial Hair (post pubertal)

Males
[250] 1☐ Sparse 2☐ Absent

Females
[251] 1☐ Excessive

→ [252] 1☐ Alopecia Areata [253] 1☐ Genetically determined
[254] 1☐ Post infection [255] 1☐ Post trauma
[256] 1☐ Endocrine [257] 1☐ Other (SPECIFY) ______

Axillary
[258] 1☐ Sparse 2☐ Absent

Pubic
[259] 1☐ Sparse 2☐ Absent (not shaved) [260] 1☐ Inappropriate escutcheon

Body Hair

Location		None	Minimal	Marked	Excessive
Anterior Thorax	261	1☐	2☐	3☐	4☐
Posterior Thorax	262	1☐	2☐	3☐	4☐
Arms	263	1☐	2☐	3☐	4☐
Legs	264	1☐	2☐	3☐	4☐
General	265	1☐	2☐	3☐	4☐

REGIONAL EXAMINATION

16. HEAD AND NECK
[266] 1☐ NO FINDINGS (GO TO ITEM 17)

Scalp
[267] 1☐ Scaling 2☐ Erythema 3☐ Both

Impressions:
[268] 1☐ Seborrheic dermatitis
[269] 1☐ Trauma
[270] 1☐ Psoriasis
[271] 1☐ Other

Eyes

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

Ears
Deformed
[296] 1☐ Acquired 2☐ Congenital
[297] 1☐ Chondodermatitis helicis nodularis

Nose
Deformed
[298] 1☐ Acquired 2☐ Congenital (saddle, etc.)

Mouth

Observation	Lips		Buccal Mucosa		Gingiva		Tongue	
Fissuring	299	1☐	300	1☐	301	1☐	302	1☐
Pigmented les.	303	1☐	304	1☐	305	1☐	306	1☐
Leukoplakia	307	1☐	308	1☐	309	1☐	310	1☐
Lichen Planus	311	1☐	312	1☐	313	1☐	314	1☐
Tumor	315	1☐	316	1☐	317	1☐	318	1☐
Angular les. or scars	319	1☐						
Cheilosis	320	1☐						

Tongue (cont'd.) General macroglossia
Mal developed generally
[321] 1☐ Forked [322] 1☐ Partial atrophy 2☐ Full atrophy
Papillae
[323] 1☐ Atrophic [324] 1☐ Geographic 2☐ Black hairy 3☐ Pyramidal 4☐ Scrotal

Palate
[325] 1☐ Smokers 2☐ Glandular hypertrophy (non-smokers) [326] 1☐ Arched 2☐ Cleft 3☐ Both

Color
[327] 1☐ Beefy red 2☐ Magenta

Other findings.
[328] 1☐ Serrations (marginal bilateral) 2☐ Swelling (marginal bilateral) 3☐ Both

17. THORAX AND ABDOMEN ——— [329] 1☐ NO FINDINGS (GO TO ITEM 18)
Supernumerary areolae: [330] ____ number with glandular tissue
[331] ____ number without glandular tissue
Gynecomastia: [332] 1☐ Minimal 2☐ Marked → Etiology [333] 1☐ Medication 2☐ Liver dysfunction 3☐ Both
Striae: [334] 1☐ Purple [335] 1☐ White [336] 1☐ Pigmented
[337] 1☐ Draining fistulae or other lesions
[338] 1☐ Congenital malformations

18. THIGHS AND BUTTOCKS
[339] 1☐ NO FINDINGS (GO TO ITEM 19)
[340] 1☐ Venous stars
[341] 1☐ Pilonidal cysts-dimple
2☐ Pilonidal cysts-drainage
3☐ Pilonidal cysts-no drainage
4☐ Pilonidal cysts-repaired
[342] 1☐ Rectal fistula
2☐ Rectal fissure and ulceration
3☐ Both
[343] 1☐ Inter-gluteal fissure

19. GENITALIA
[344] 1☐ NO FINDINGS (GO TO ITEM 20)
[345] 1☐ Chancre 2☐ Other VD 3☐ Both
Redness and scaling due to: [347] 1☐ Psoriasis 2☐ Seborrheic dermatitis
[346] 1☐ Ulcers [348] 1☐ Candida 2☐ Parasites 3☐ Both 4☐ Uncertain

20. EXTREMITIES
[349] 1☐ NO FINDINGS (GO TO ITEM 21)

	Severity Min.	Mod.	Severe	Disfiguring Yes	No
Clubbing acquired	350 1☐	2☐	3☐	351 1☐	2☐
Clubbing familial	352 1☐	2☐	3☐	353 1☐	2☐
Deformity, acquired	354 1☐	2☐	3☐	355 1☐	2☐
Deformity, familial	356 1☐	2☐	3☐	357 1☐	2☐

Varicosities		Min.	Mod.	Severe
Right	358	1☐	2☐	3☐
Left	359	1☐	2☐	3☐

Follicular hyperkeratosis		No color change	Peri-foll. redness
Upper-outer arm	360	1☐	2☐
Rest of upper extrem.	361	1☐	2☐
Entire arm	362	1☐	2☐
Upper-outer legs	363	1☐	2☐
Rest of lower extrem.	364	1☐	2☐
Entire leg	365	1☐	2☐
Upper back	366	1☐	2☐
Abdomen	367	1☐	2☐
Buttocks	368	1☐	2☐

DISEASE ORIENTED EXAMINATION

[369] 1[ ] NO DISEASE [(ITEMS 21-31) SKIP TO EVALUATION ON NEXT PAGE-]

21. ACNE VULGARIS

[370] 1☐ Inactive
2☐ Active →

	Min.	Mod.	Severe
[371]	1☐	2☐	3☐

Acne cysts
[372] 1☐ Quiescent 2☐ Active
[373] 1☐ Pit scarring
[374] 1☐ Cystic scarring

Extent of acne
[375] 1☐ Face [377] 1☐ Chest
[376] 1☐ Back

22. SECONDARY ACNE (CHECK ONE)

[378] 1☐ Steriod 3☐ Anovulatory preparations
2☐ Halogen 4☐ Oil

ACNE ROSACEA
[379] 1☐ Minimal 3☐ Severe
2☐ Moderate

23. SEBORRHEIC DERMATITIS (CHECK ALL THAT APPLY)

[380] 1☐ Naso labial fold [381] 1☐ Eyebrows
[382] 1☐ Scalp [383] 1☐ Post auricular
[384] 1☐ Axillae [385] 1☐ Genitalia
[386] 1☐ Infra mammary

Culture taken for Candida? [387] 1☐ Yes 2☐ No

24. PSORIASIS

[388] 1☐ Inactive
2☐ Active →

	Min.	Mod.	Severe
[389]	1☐	2☐	3☐

Location
[390] 1☐ Scalp only [391] 1☐ Trunk
2☐ Extremities only 2☐ Seborrheic areas only
3☐ Both 3☐ Both

Joint Involved
[392] 1☐ Fingers 2☐ Toes 3☐ Both
[393] 1☐ Spine
[394] 1☐ Other joint (SPECIFY)____

Family History
[395] 1☐ Parent 2☐ Sibs 3☐ Parents and sibs
[396] 1☐ Near relatives

Did joint problem precede psoriasis?
[397] 1☐ Yes 2☐ No

25. ATOPIC DERMATITIS

Severity
[398] 1☐ Minimal 2☐ Moderate 3☐ Severe

Distribution
[399] 1☐ Flexural areas only
2☐ Flexural areas and other (SPECIFY)____
3☐ Generalized

Family History
[400] 1☐ Atopy
[401] 1☐ Urticaria and/or asthma

Personal History
[402] 1☐ Urticaria and/or asthma

26. URTICARIA (CHECK ALL THAT APPLY)

[403] 1☐ Cholinergic [404] 1☐ Angio-neurotic edema
[405] 1☐ Giant [406] 1☐ Cold
[407] 1☐ Ordinary urticaria

26. (cont'd) Cause of Urticaria (CHECK ALL THAT APPLY)

[408] 1☐ Food [409] 1☐ Inhalant
[410] 1☐ Medication [411] 1☐ Obscure or other (SPECIFY)____

27. CONTACT DERMATITIS (CHECK ALL THAT APPLY)

[412] 1☐ Plant [413] 1☐ Rubber
[414] 1☐ Medication [415] 1☐ Leather
[416] 1☐ Chemical [417] 1☐ Cosmetics
[418] 1☐ Metal [419] 1☐ Obscure
[420] 1☐ Fabrics

28. FUNGAL INFECTIONS

Site	Impression Yes	Impression No	KOH Pos.	KOH Neg.	KOH N.D.	Wood's Lamp Pos.	Wood's Lamp Neg.	Wood's Lamp N.D.
Scalp	[421] 1☐	2☐	[422] 1☐	2☐	3☐	[423] 1☐	2☐	3☐
Feet	[424] 1☐	2☐	[425] 1☐	2☐	3☐	[426] 1☐	2☐	3☐
Hands	[427] 1☐	2☐	[428] 1[ ]	2☐	3☐	[429] 1☐	2☐	3☐
Groin	[430] 1☐	2☐	[431] 1☐	2☐	3☐	[432] 1☐	2☐	3☐
Other (SPECIFY)	[433] 1☐	2☐	[434] 1☐	2☐	3☐	[435] 1☐	2☐	3☐

Culture taken for Fungi
[436] 1☐ None taken
Feet: [437] 1☐ Nail 3☐ Glabrous skin
2☐ Webs 4☐ Combination
Hands: [438] 1☐ Nail 3☐ Both
2☐ Glabrous skin
[439] 1☐ Groin
[440] 1☐ Body

29. VIRAL INFECTIONS (EXCEPT WARTS)

Viral Vesicles: Diagnostic Impression
[441] 1☐ H. Simplex 3☐ M. Contagiosum
2☐ H. Zoster 4☐ Primary Varicella

Tzanck smear
[442] 1☐ Positive 2☐ Negative 3☐ Not done

30. BACTERIAL INFECTIONS

Description/Severity		Location: Scalp	Face	Trunk	Extrem.	Butt.	Cult?
Furuncles		[443]	[444]	[445]	[446]	[447]	[448]
	Min.	1☐	1☐	1☐	1☐	1☐	
	Mod.	2☐	2☐	2☐	2☐	2☐	1☐ Yes
	Severe	3☐	3☐	3☐	3☐	3☐	
Folliculitis		[449]	[450]	[451]	[452]	[453]	[454]
	Min.	1☐	1☐	1☐	1☐	1☐	
	Mod.	2☐	2☐	2☐	2☐	2☐	1☐ Yes
	Severe	3☐	3☐	3☐	3☐	3☐	
Impetigo		[455]	[456]	[457]	[458]	[459]	[460]
	Min.	1☐	1☐	1☐	1☐	1☐	
	Mod.	2☐	2☐	2☐	2☐	2☐	1☐ Yes
	Severe	3☐	3☐	3☐	3☐	3☐	
TBC		[461]	[462]	[463]	[464]	[465]	[466]
	Min.	1☐	1☐	1☐	1☐	1☐	
	Mod.	2☐	2☐	2☐	2☐	2☐	1☐ Yes
	Severe	3☐	3☐	3☐	3☐	3☐	
Hansen's Disease		[467]	[468]	[469]	[470]	[471]	[472]
	Min.	1☐	1☐	1☐	1☐	1☐	
	Mod.	2☐	2☐	2☐	2☐	2☐	1☐ Yes
	Severe	3☐	3☐	3☐	3☐	3☐	
Swim. Pool Gran.		[473]	[474]	[475]	[476]	[477]	[478]
	Min.	1☐	1☐	1☐	1☐	1☐	
	Mod.	2☐	2☐	2☐	2☐	2☐	1☐ Yes
	Severe	3☐	3☐	3☐	3☐	3☐	

31. ARTHROPOD AND PROTOZOAN INFECTIONS

[479] 1☐ Pediculosis capitis [480] 1☐ Swimmer's itch
[481] 1☐ Pediculosis pubis [482] 1☐ Mites
[483] 1☐ Pediculosis corporis [484] 1☐ Leishmaniasis
[485] 1☐ Creeping eruption

EVALUATION OF DERMATOLOGICAL COMPLAINT

[486] 1☐ NO CONDITIONS (END OF EXAM)

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

EVALUATION		SEVERITY: NONE	MIN.	MOD.	SEVERE
37. Disfigurement (examiner eval.)					
Hand	[542]	1☐	2☐	3☐	4☐
Foot	[543]	1☐	2☐	3☐	4☐
Other	[544]	1☐	2☐	3☐	4☐
38. Discomfort (Patient evaluation)					
a. Pain or Burning- Hand	[545]	1☐	2☐	3☐	4☐
Foot	[546]	1☐	2☐	3☐	4☐
Other	[547]	1☐	2☐	3☐	4☐
b. Itching					
Hand	[548]	1☐	2☐	3☐	4☐
Foot	[549]	1☐	2☐	3☐	4☐
Other	[550]	1☐	2☐	3☐	4☐
c. Limitation of Motion-					
Hand	[551]	1☐	2☐	3☐	4☐
Foot	[552]	1☐	2☐	3☐	4☐
Other	[553]	1☐	2☐	3☐	4☐
d. Overall Discomfort					
Hand	[554]	1☐	2☐	3☐	4☐
Foot	[555]	1☐	2☐	3☐	4☐
Other	[556]	1☐	2☐	3☐	4☐

39. OBSTACLE TO IMPROVEMENT OF CONDITION (CHECK ALL THAT APPLY)

[557] 1☐ No medical advice sought
2☐ Inadequate medical advice
[558] 1☐ Patient cooperation
[559] 1☐ Distance from medical help
[560] 1☐ Availability of transportation
[561] 1☐ Finances
[562] 1☐ Other ____________

HSM-425-13A (PAGE 1)
REV. 8/71

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

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

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

OPHTHALMOLOGY EXAMINATION

a. Deck No.	b. Sample No.	c. Sex	d. Age	e. Examiner No.	f. Name of examiner
162	_ _ _ _ _	1 ☐ Male 2 ☐ Female	_ _	_ _	

A. SIGNIFICANT OCULAR HISTORY — (001) 1 ☐ Yes 2 ☐ No

1. Surgery – ☐ Strabismus ☐ Cataract — (002) _ _ _ _ _ _
2. Other – ☐ Injury ☐ Infection — (003) _ _ _ _ _ _
3. Other – *Specify* ________ — (004) _ _ _ _ _ _

B. VISUAL ACUITY

1. Optotype used . . . . 1. — (005) 1 ☐ Snellen 2 ☐ Ill. E
2. Acuity
   - cc OD ______ 2. — (006) *_ _
   - OS ______ — (007) *_ _
   - sc OD ______ — (008) *_ _
   - OS ______ — (009) *_ _
3. If not 20/20, pinhole (Acuity) . . . . 3.
   - OD ______ — (010) *_ _
   - OS ______ — (011) *_ _

*To be entered by coder

C. MOTILITY

1. Tropia . . . . 1. — (012) 1 ☐ Eso 2 ☐ Exo 3 ☐ Neither; (013) 1 ☐ Hyper 2 ☐ Not hyper; (014) 1 ☐ Comitant 2 ☐ Incomitant
2. Phoria . . . . 2. — (015) 1 ☐ Eso 2 ☐ Exo 3 ☐ Neither; (016) 1 ☐ Hyper 2 ☐ Not hyper
3. Nystagmus . . . . 3. — (017) 1 ☐ Pendular 2 ☐ Jerk-horiz. 3 ☐ Jerk-vert. 4 ☐ Jerk-rotary 5 ☐ No nystagmus

D. PUPILS

		OD	OS	OU
1. Anisocoria – location . . . . 1.	(018)	1 ☐	2 ☐	3 ☐
a. –(mm) . . . . a.		____	____	____
2. Absent light reflex a. Direct . . . . 2a.	(019)	1 ☐	2 ☐	3 ☐
b. Consensual . . . . b.	(020)	1 ☐	2 ☐	3 ☐
3. Other – *Specify* ______ 3.	(021)	1 ☐	2 ☐	3 ☐
4. No abnormality . . . . 4.	(022)	1 ☐	2 ☐	3 ☐

E. TONOMETRY – *Three readings*

Time of test ______ a.m. p.m.

☐ Unsatisfactory test (*Code 99 in space 023*)

Applanation

OD		OS	
(023)	_ _	(024)	_ _
(025)	_ _	(026)	_ _
(027)	_ _	(028)	_ _

Anterior segment check prior to dilatation.

F. DILATATION (1 gtt. 10% Phenylephrine OU)

(029) 1 ☐ Not dilated:
- ☐ Suspicious anterior chamber
- ☐ History of angle closure
- ☐ Unable to instill gtts.

2 ☐ Mydriasis inadequate for fundus copy

3 ☐ Dilatation adequate

H. MAXILLARY SINUS TRANSILLUMINATION (For detailed examinees only)

1. Right . . . . 1. — (033) 1 ☐ Normal 2 ☐ Dull 3 ☐ Opaque
2. Left . . . . 2. — (034) 1 ☐ Normal 2 ☐ Dull 3 ☐ Opaque

NOTES

I. REFRACTION	Eye	Sphere		Cylinder		Axis	VA	PH
1. Present glasses	OD	035 1☐ + 2☐ -	036 __.__ D	037 1☐ + 2☐ -	038 __.__ D	039 ___°		
	OS	040 1☐ + 2☐ -	041 __.__ D	042 1☐ + 2☐ -	043 __.__ D	044 ___°		
2. If acuity less than 20/40, retinoscopy	OD	045 1☐ + 2☐ -	046 __.__ D	047** 1☐ + 2☐ -	048** __.__ D	049** ___°	050 __ c=__	051** __ c=__
* To be entered by coder	OS	052 1☐ + 2☐ -	053 __.__ D	054** 1☐ + 2☐ -	055** __.__ D	056** ___°	057 __ c=__	058** __ c=__

J. LIDS			OD	OS	OU
1. Blepharitis	1.	(059)	1☐	2☐	3☐
a. Angular	a.	(060)	1☐	2☐	3☐
2. Chalazion	2.	(061)	1☐	2☐	3☐
3. Concretions	3.	(062)	1☐	2☐	3☐
4. Ectropion	4.	(063)	1☐	2☐	3☐
5. Entropion	5.	(064)	1☐	2☐	3☐
6. Hordeolum	6.	(065)	1☐	2☐	3☐
7. Ptosis	7.	(066)	1☐	2☐	3☐
8. Other – *Specify* ______	8.	(067)	1☐	2☐	3☐
9. No abnormality	9.	(068)	1☐	2☐	3☐

K. GLOBE			OD	OS	OU
1. Enucleation	1.	(069)	1☐	2☐	3☐
2. Exophthalmos	2.	(070)	1☐	2☐	3☐
a. Measurement	a.		____	____	____
b. Base	b.		____	____	____
3. Microphthalmos	3.	(071)	1☐	2☐	3☐
a. Measurement (mm)	a.		____	____	____
4. Other – *Specify* ______	4.	(072)	1☐	2☐	3☐
5. No abnormality	5.	(073)	1☐	2☐	3☐

L. CONJUNCTIVA			OD	OS	OU
1. Bitot's spot	1.	(074)	1☐	2☐	3☐
2. Conjunctivitis					
a. Allergic	2a.	(075)	1☐	2☐	3☐
b. Follicular	b.	(076)	1☐	2☐	3☐
c. Infectious	c.	(077)	1☐	2☐	3☐
(1) Bacterial – *Specify* ______	(1)	(078)	1☐	2☐	3☐
(2) Viral – *Specify* ______	(2)	(079)	1☐	2☐	3☐
3. Follicles (no inflammation)	3.	(080)	1☐	2☐	3☐
4. Inclusions	4.	(081)	1☐	2☐	3☐
5. Pingueculum	5.	(082)	1☐	2☐	3☐
6. Xerosis	6.	(083)	1☐	2☐	3☐
7. Other – *Specify* ______	7.	(084)	1☐	2☐	3☐
8. No abnormality	8.	(085)	1☐	2☐	3☐

M. SCLERA			OD	OS	OU
1. Ectasia	1.	(086)	1☐	2☐	3☐
2. Episcleritis	2.	(087)	1☐	2☐	3☐
3. Scleritis	3.	(088)	1☐	2☐	3☐
4. Other – *Specify* ______	4.	(089)	1☐	2☐	3☐
5. No abnormality	5.	(090)	1☐	2☐	3☐

NOTES

** For detailed examinees only.

N. CORNEA

Item		Code	OD	OS	OU
1. Arcus senilis	1.	(091)	1 ☐	2 ☐	3 ☐
2. Band keratopathy	2.	(092)	1 ☐	2 ☐	3 ☐
3. Degeneration – *Specify* ________	3.	(093)	1 ☐	2 ☐	3 ☐
4. Dystrophy – *Specify* ________	4.	(094)	1 ☐	2 ☐	3 ☐
5. Edema					
a. Epithelial	5a.	(095)	1 ☐	2 ☐	3 ☐
b. Stromal	b.	(096)	1 ☐	2 ☐	3 ☐
6. Endothelial KP's	6.	(097)	1 ☐	2 ☐	3 ☐
7. Guttata	7.	(098)	1 ☐	2 ☐	3 ☐
8. Keratitis – *Specify* ________	8.	(099)	1 ☐	2 ☐	3 ☐
9. Keratomalacia	9.	(100)	1 ☐	2 ☐	3 ☐
10. Krukenberg spindle	10.	(101)	1 ☐	2 ☐	3 ☐
11. Opacity – *Specify* ________	11.	(102)	1 ☐	2 ☐	3 ☐
a. Superficial stromal	a.	(103)	1 ☐	2 ☐	3 ☐
12. Pterygium	12.	(104)	1 ☐	2 ☐	3 ☐
13. Vessels – *Specify* ________	13.	(105)	1 ☐	2 ☐	3 ☐
14. Other – *Specify* ________	14.	(106)	1 ☐	2 ☐	3 ☐
15. No abnormality	15.	(107)	1 ☐	2 ☐	3 ☐
16. Diagram location of abnormalities	16.	(108)	1 ☐ Location shown		
			OD ◯	OS ◯	

O. ANTERIOR CHAMBER

Item		Code	OD	OS	OU
1. Cells	1.	(109)	1 ☐	2 ☐	3 ☐
2. Flare	2.	(110)	1 ☐	2 ☐	3 ☐
3. Other – *Specify* ________	3.	(111)	1 ☐	2 ☐	3 ☐
4. No abnormality	4.	(112)	1 ☐	2 ☐	3 ☐

P. IRIS

Item		Code	OD	OS	OU
1. Synechiae					
a. Anterior	1a.	(113)	1 ☐	2 ☐	3 ☐
b. Posterior	b.	(114)	1 ☐	2 ☐	3 ☐
2. Atrophy	2.	(115)	1 ☐	2 ☐	3 ☐
3. Coloboma	3.	(116)	1 ☐	2 ☐	3 ☐
4. Iritis	4.	(117)	1 ☐	2 ☐	3 ☐
5. Neovascularization	5.	(118)	1 ☐	2 ☐	3 ☐
6. Other – *Specify* ________	6.	(119)	1 ☐	2 ☐	3 ☐
7. No abnormality	7.	(120)	1 ☐	2 ☐	3 ☐

Q. LENS

Item		Code	OD	OS	OU
1. Aphakia	1.	(121)	1 ☐	2 ☐	3 ☐
2. Cataract					
a. Immature	2a.	(122)	1 ☐	2 ☐	3 ☐
b. Intumescent	b.	(123)	1 ☐	2 ☐	3 ☐
c. Mature	c.	(124)	1 ☐	2 ☐	3 ☐
d. Hypermature	d.	(125)	1 ☐	2 ☐	3 ☐
e. Morgagnian	e.	(126)	1 ☐	2 ☐	3 ☐
3. Opacity					
a. Anterior polar	3a.	(127)	1 ☐	2 ☐	3 ☐
b. Cortical	b.	(128)	1 ☐	2 ☐	3 ☐
c. Nuclear	c.	(129)	1 ☐	2 ☐	3 ☐
d. Post subcapsular	d.	(130)	1 ☐	2 ☐	3 ☐
4. Pigment on surface	4.	(131)	1 ☐	2 ☐	3 ☐
5. Other – *Specify* ________	5.	(132)	1 ☐	2 ☐	3 ☐
6. No abnormality	6.	(133)	1 ☐	2 ☐	3 ☐

R. VITREOUS

Item		Code	OD	OS	OU
1. Detachment	1.	(134)	1 ☐	2 ☐	3 ☐
2. Hemorrhage	2.	(135)	1 ☐	2 ☐	3 ☐
3. Opacity – *Specify* ________	3.	(136)	1 ☐	2 ☐	3 ☐
4. Other – *Specify* ________	4.	(137)	1 ☐	2 ☐	3 ☐
5. No abnormality	5.	(138)	1 ☐	2 ☐	3 ☐

5. RETINA			OD	OS	OU
1. Disc					
a. Drusen	1a.	(139)	1 ☐	2 ☐	3 ☐
b. Glaucomatous cup	b.	(140)	1 ☐	2 ☐	3 ☐
c. Neovascularization	c.	(141)	1 ☐	2 ☐	3 ☐
d. Optic atrophy					
(1) Primary	d(1)	(142)	1 ☐	2 ☐	3 ☐
(2) Secondary	(2)	(143)	1 ☐	2 ☐	3 ☐
e. Papilledema	e.	(144)	1 ☐	2 ☐	3 ☐
f. Papillitis	f.	(145)	1 ☐	2 ☐	3 ☐
g. Other – *Specify* ______________	g.	(146)	1 ☐	2 ☐	3 ☐
2. Macula					
a. Degeneration					
(1) Senile	2a(1)	(147)	1 ☐	2 ☐	3 ☐
(2) Disciform	(2)	(148)	1 ☐	2 ☐	3 ☐
(3) Circinate	(3)	(149)	1 ☐	2 ☐	3 ☐
b. Diabetic involvement	b.	(150)	1 ☐	2 ☐	3 ☐
c. Edema	c.	(151)	1 ☐	2 ☐	3 ☐
d. Hypertensive involve	d.	(152)	1 ☐	2 ☐	3 ☐
e. Pigment epith. detach	e.	(153)	1 ☐	2 ☐	3 ☐
f. Other – *Specify* ______________	f.	(154)	1 ☐	2 ☐	3 ☐
3. Vessels					
a. Arteries					
(1) Branch occlusion	3a(1)	(155)	1 ☐	2 ☐	3 ☐
(2) Central occlusion	(2)	(156)	1 ☐	2 ☐	3 ☐
(3) Gen. narrow (1–4)	(3)	(157)	1 ☐	2 ☐	3 ☐
(4) Sclerosis (1–4)	(4)	(158)	1 ☐	2 ☐	3 ☐
b. Veins					
(1) Branch occlusion	b(1)	(159)	1 ☐	2 ☐	3 ☐
(2) Central occlusion	(2)	(160)	1 ☐	2 ☐	3 ☐
(3) Dilatation	(3)	(161)	1 ☐	2 ☐	3 ☐
(4) Sausaging	(4)	(162)	1 ☐	2 ☐	3 ☐
(5) Sheathing	(5)	(163)	1 ☐	2 ☐	3 ☐
(6) Tortuosity	(6)	(164)	1 ☐	2 ☐	3 ☐
c. Capillaries					
(1) Microaneurysms	c(1)	(165)	1 ☐	2 ☐	3 ☐
(2) Neovascularization	(2)	(166)	1 ☐	2 ☐	3 ☐
d. Other – *Specify* ______________	d.	(167)	1 ☐	2 ☐	3 ☐
4. Exudates					
a. Cotton wool	4a.	(168)	1 ☐	2 ☐	3 ☐
b. Hard	b.	(169)	1 ☐	2 ☐	3 ☐
c. Waxy	c.	(170)	1 ☐	2 ☐	3 ☐
d. Other – *Specify* ______________	d.	(171)	1 ☐	2 ☐	3 ☐
5. Hemorrhages					
a. Choroidal	5a.	(172)	1 ☐	2 ☐	3 ☐
b. Preretinal	b.	(173)	1 ☐	2 ☐	3 ☐
c. Retinal					
(1) Deep	c(1)	(174)	1 ☐	2 ☐	3 ☐
(2) Superficial	(2)	(175)	1 ☐	2 ☐	3 ☐
d. Other – *Specify* ______________	d.	(176)	1 ☐	2 ☐	3 ☐
6. Pigment changes					
a. Choroidal	6a.	(177)	1 ☐	2 ☐	3 ☐
b. Epithelial					
(1) Atrophy	b(1)	(178)	1 ☐	2 ☐	3 ☐
(2) Hyperplasia	(2)	(179)	1 ☐	2 ☐	3 ☐
c. Other – *Specify* ______________	c.	(180)	1 ☐	2 ☐	3 ☐
7. Angioid streaks	7.	(181)	1 ☐	2 ☐	3 ☐
8. Detachment	8.	(182)	1 ☐	2 ☐	3 ☐
9. Drusen	9.	(183)	1 ☐	2 ☐	3 ☐
10. Inflammation					
a. Chorioretinitis – *Specify* ______________	10a.	(184)	1 ☐	2 ☐	3 ☐
(1) Active	(1)	(185)	1 ☐	2 ☐	3 ☐
(2) Inactive	(2)	(186)	1 ☐	2 ☐	3 ☐
11. Retrolental fibroplasia	11.	(187)	1 ☐	2 ☐	3 ☐
12. Other – *Specify* ______________	12.	(188)	1 ☐	2 ☐	3 ☐
13. No abnormality	13.	(189)	1 ☐	2 ☐	3 ☐
14. Not visualized	14.	(190)	1 ☐	2 ☐	3 ☐

S. RETINA – Continued

15. Diagram location of retinal abnormalities

(191) 1 ☐ Location shown

OD OS

T. OPHTHALMIC DIAGNOSIS

(192) 1 ☐ Incomplete examination
2 ☐ No abnormality
3 ☐ Abnormality

Mark column applicable, leave blank if unknown

	Code	Condition decreases vision	Treatment				Eye affected			
				Needed	Under care	Not needed		OD	OS	OU
1. Amblyopia	193 1 ☐ Present	194 1 ☐ Yes 2 ☐ No	195	1 ☐	2 ☐	3 ☐	196	1 ☐	2 ☐	3 ☐
2.	197 _ _ _ _ _ _ _	198 1 ☐ Yes 2 ☐ No	199	1 ☐	2 ☐	3 ☐	200	1 ☐	2 ☐	3 ☐
3.	201 _ _ _ _ _ _ _	202 1 ☐ Yes 2 ☐ No	203	1 ☐	2 ☐	3 ☐	204	1 ☐	2 ☐	3 ☐
4.	205 _ _ _ _ _ _ _	206 1 ☐ Yes 2 ☐ No	207	1 ☐	2 ☐	3 ☐	208	1 ☐	2 ☐	3 ☐
5.	209 _ _ _ _ _ _ _	210 1 ☐ Yes 2 ☐ No	211	1 ☐	2 ☐	3 ☐	212	1 ☐	2 ☐	3 ☐
6.	213 _ _ _ _ _ _ _	214 1 ☐ Yes 2 ☐ No	215	1 ☐	2 ☐	3 ☐	216	1 ☐	2 ☐	3 ☐

NOTES

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

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

HEALTH AND NUTRITION EXAMINATION SURVEY IV
DENTAL EXAMINATION

NAME

	0	1	2	3	4		5	6	7	8	9
AGE	0	1	2	3	4	TENS	5	6	7	8	9
	0	1	2	3	4	UNITS	5	6	7	8	9
SEX—RACE	MW	FW	MN	FN			MO	FO			

0	1	2	3	4		5	6	7	8	9
0	1	2	3	4	STAND	5	6	7	8	9
0	1	2	3	4	AND	5	6	7	8	9
0	1	2	3	4	CONTROL	5	6	7	8	9
0	1	2	3	4		5	6	7	8	9
					EXAMINEE					
0	1	2	3	4		5	6	7	8	9
0	1	2	3	4		5	6	7	8	9
0	1	2	3	4		5	6	7	8	9

UPPER LEFT						UPPER RIGHT						LOWER LEFT						LOWER RIGHT				
XD	D	2	0	JR		XD	D	2	0	JR	CENTRAL	XD	D	2	0	JR		XD	D	2	0	JR
6X	3	0	4X	5X	OCC	6X	3	0	4X	5X		6X	3	0	4X	5X	OCC	6X	3	0	4X	5X
60			40	50	LIN	60			40	50		60			40	50	LIN	60			40	50
61			41	51	BUC	61			41	51		61			41	51	BUC	61			41	51
62	F	R	42	52	MES	62	F	R	42	52		62	F	R	42	52	MES	62	F	R	42	52
63	FD	RD	43	53	DIS	63	FD	RD	43	53		63	FD	RD	43	53	DIS	63	FD	RD	43	53
XD	D	2	0	JR		XD	D	2	0	JR	LATERAL	XD	D	2	0	JR		XD	D	2	0	JR
6X	3	0	4X	5X	OCC	6X	3	0	4X	5X		6X	3	0	4X	5X	OCC	6X	3	0	4X	5X
60			40	50	LIN	60			40	50		60			40	50	LIN	60			40	50
61			41	51	BUC	61			41	51		61			41	51	BUC	61			41	51
62	F	R	42	52	MES	62	F	R	42	52		62	F	R	42	52	MES	62	F	R	42	52
63	FD	RD	43	53	DIS	63	FD	RD	43	53		63	FD	RD	43	53	DIS	63	FD	RD	43	53
XD	D	2	0	JR		XD	D	2	0	JR	CUSPID	XD	D	2	0	JR		XD	D	2	0	JR
6X	3	0	4X	5X	OCC	6X	3	0	4X	5X		6X	3	0	4X	5X	OCC	6X	3	0	4X	5X
60			40	50	LIN	60			40	50		60			40	50	LIN	60			40	50
61			41	51	BUC	61			41	51		61			41	51	BUC	61			41	51
62	F	R	42	52	MES	62	F	R	42	52		62	F	R	42	52	MES	62	F	R	42	52
63	FD	RD	43	53	DIS	63	FD	RD	43	53		63	FD	RD	43	53	DIS	63	FD	RD	43	53
XD	D	2	0	JR		XD	D	2	0	JR	1ST BICUSPID	XD	D	2	0	JR		XD	D	2	0	JR
6X	3	0	4X	5X	OCC	6X	3	0	4X	5X		6X	3	0	4X	5X	OCC	6X	3	0	4X	5X
60			40	50	LIN	60			40	50		60			40	50	LIN	60			40	50
61			41	51	BUC	61			41	51		61			41	51	BUC	61			41	51
62	F	R	42	52	MES	62	F	R	42	52		62	F	R	42	52	MES	62	F	R	42	52
63	FD	RD	43	53	DIS	63	FD	RD	43	53		63	FD	RD	43	53	DIS	63	FD	RD	43	53
XD	D	2	0	JR		XD	D	2	0	JR	2ND BICUSPID	XD	D	2	0	JR		XD	D	2	0	JR
6X	3	0	4X	5X	OCC	6X	3	0	4X	5X		6X	3	0	4X	5X	OCC	6X	3	0	4X	5X
60			40	50	LIN	60			40	50		60			40	50	LIN	60			40	50
61			41	51	BUC	61			41	51		61			41	51	BUC	61			41	51
62	F	R	42	52	MES	62	F	R	42	52		62	F	R	42	52	MES	62	F	R	42	52
63	FD	RD	43	53	DIS	63	FD	RD	43	53		63	FD	RD	43	53	DIS	63	FD	RD	43	53
XD		2	0	JR		XD		2	0	JR	1ST MOLAR	XD		2	0	JR		XD		2	0	JR
6X	3	0	4X	5X	OCC	6X	3	0	4X	5X		6X	3	0	4X	5X	OCC	6X	3	0	4X	5X
60			40	50	LIN	60			40	50		60			40	50	LIN	60			40	50
61			41	51	BUC	61			41	51		61			41	51	BUC	61			41	51
62	F	R	42	52	MES	62	F	R	42	52		62	F	R	42	52	MES	62	F	R	42	52
63	FD	RD	43	53	DIS	63	FD	RD	43	53		63	FD	RD	43	53	DIS	63	FD	RD	43	53

DENTAL EXAMINATION

STAND AND CONTROL									
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

UPPER LEFT						UPPER RIGHT						LOWER LEFT						LOWER RIGHT				
XD		2	0	4R		XD		2	0	4R	2ND MOLAR	XD		2	0	4R		XD		2	0	4R
8X	5	8	4X	5X	OCC	8X	5	8	4X	5X		8X	5	8	4X	5X	OCC	8X	5	8	4X	5X
80			40	50	LIN	80			40	50		80			40	50	LIN	80			40	50
81			41	51	BUC	81			41	51		81			41	51	BUC	81			41	51
82	F	R	42	52	MES	82	F	R	42	52		82	F	R	42	52	MES	82	F	R	42	52
83	FD	RD	43	53	DIS	83	FD	RD	43	53		83	FD	RD	43	53	DIS	83	FD	RD	43	53
XD		2	0	4R		XD		2	0	4R	3RD MOLAR	XD		2	0	4R		XD		2	0	4R
8X	5	8	4X	5X	OCC	8X	5	8	4X	5X		8X	5	8	4X	5X	OCC	8X	5	8	4X	5X
80			40	50	LIN	80			40	50		80			40	50	LIN	80			40	50
81			41	51	BUC	81			41	51		81			41	51	BUC	81			41	51
82	F	R	42	52	MES	82	F	R	42	52		82	F	R	42	52	MES	82	F	R	42	52
83	FD	RD	43	53	DIS	83	FD	RD	43	53		83	FD	RD	43	53	DIS	83	FD	RD	43	53

PERIODONTAL INDEX (NO P. I)				QUADRANT	MISSING OR ROOTS ONLY (NA)	TOOTH SPACE	MISSING OR ROOTS ONLY (NA)	QUADRANT	PERIODONTAL INDEX			
1	2	6	8		X		X		1	2	6	8
1	1	1	1	UPPER ARCH RIGHT	1	3RD MOLAR	17	LOWER ARCH LEFT	17	17	17	17
2	2	2	2		2	2ND MOLAR	18		18	18	18	18
3	3	3	3		3	1ST MOLAR	19		19	19	19	19
4	4	4	4		4	2ND BI	20		20	20	20	20
5	5	5	5		5	1ST BI	21		21	21	21	21
6	6	6	6		6	CUSPID	22		22	22	22	22
7	7	7	7		7	LATERAL	23		23	23	23	23
8	8	8	8		8	CENTRAL	24		24	24	24	24
1	2	6	8		X		X		1	2	6	8
9	9	9	9	UPPER ARCH LEFT	9	CENTRAL	25	LOWER ARCH RIGHT	25	25	25	25
10	10	10	10		10	LATERAL	26		26	26	26	26
11	11	11	11		11	CUSPID	27		27	27	27	27
12	12	12	12		12	1ST BI	28		28	28	28	28
13	13	13	13		13	2ND BI	29		29	29	29	29
14	14	14	14		14	1ST MOLAR	30		30	30	30	30
15	15	15	15		15	2ND MOLAR	31		31	31	31	31
16	16	16	16		16	3RD MOLAR	32		32	32	32	32

OPACITIES	NON-FLUORIDE	FLUORIDE
NONE		
MILD		
MODERATE SEVERE		
NA		

OTHER CONDITIONS	YES	NO
BLEEDING GUMS		
DIFFUSE MARGINAL INFLAMMATION		
SWOLLEN RED PAPILLAE		
RECESSION		

FOUR OR MORE PAIRS OF OPPOSING SERVICEABLE POSTERIOR TEETH — PRESENT / ABSENT

ORTHODONTIC APPLIANCE — PRESENT / ABSENT

ORAL HYGIENE INDEX

UPPER ARCH									LOWER ARCH								
RIGHT			ANTERIOR			LEFT			RIGHT			ANTERIOR			LEFT		
DEBRIS		CALCULUS	DEBRIS		CALCULUS	DEBRIS		CALCULUS	DEBRIS		CALCULUS	DEBRIS		CALCULUS	DEBRIS		CALCULUS
0	NONE	0	0	NONE	0	0	NONE	0	0	NONE	0	0	NONE	0	0	NONE	0
1	1/3	1	1	1/3	1	1	1/3	1	1	1/3	1	1	1/3	1	1	1/3	1
2	2/3	2	2	2/3	2	2	2/3	2	2	2/3	2	2	2/3	2	2	2/3	2
3	2/3+	3	3	2/3+	3	3	2/3+	3	3	2/3+	3	3	2/3+	3	3	2/3+	3
NA		NA	NA		NA	NA		NA	NA		NA	NA		NA	NA		NA

DENTAL EXAMINATION

STAND AND CONTROL

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

BUCCAL SEGMENT RELATION

RIGHT	LEFT	
1	1	MESIAL–SEVERE
2	2	–MODERATE
3	3	NORMAL
4	4	DISTAL–MODERATE
5	5	–SEVERE
NA	NA	NOT APPLICABLE
		PRIMARY ARCH

POSTERIOR CROSSBITE

RIGHT BUCCAL	RIGHT LINGUAL	LEFT BUCCAL	LEFT LINGUAL
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
NA	NA	NA	NA

ENAMEL BIOPSY

NO TEETH ABSENT

NO EQUIPMENT FAILURE

NO OTHER REASON ______

YES — TOOTH: 7 8 10 9

HLD INDEX (HANDICAPPING LABIO-LINGUAL DEVIATIONS)

OVERJET		MANDIBULAR PROTRUSION		INCISOR RELATIONSHIP	OVERBITE		OPENBITE		LABIO-LINGUAL SPREAD		DEFORMITY
				OPENBITE (MM)							
0	0	0	0		0	0	0	0	0	0	ABSENT
1	1	1	1	1 4+	1	1	1	1	1	1	
2	2	2	2	2 2+–4	2	2	2	2	2	2	PRESENT
3	3	3	3	3 0-2	3	3	3	3	3	3	
	4		4	OVERBITE		4		4		4	
	5		5	4 INC 3RD		5		5		5	
	6		6	5 MID 3RD		6		6		6	
	7		7	6 GIN 3RD		7		7		7	
	8		8	7 TISSUE		8		8		8	
	9		9	8 IMPINGING OVERBITE		9		9		9	
	NA		NA	NA NOT APPLICABLE		NA		NA		NA	

MALALIGNED TEETH

UPPER NA

ANTERIOR

0 1 2 3 4 MINOR 5 6

0 1 2 3 4 MAJOR 5 6

POSTERIOR

0 1 2 3 4 MINOR 5 6 7 8 9

0 1 2 3 4 MAJOR 5 6 7 8 9

LOWER

ANTERIOR

0 1 2 3 4 MINOR 5 6

0 1 2 3 4 MAJOR 5 6

POSTERIOR

0 1 2 3 4 MINOR 5 6 7 8 9

0 1 2 3 4 MAJOR 5 6 7 8 9

EXAMINER 1 2 3 4 5 6 7 8

RECORDER 1 2 3 4 5 6 7 8

EDENTULOUS ARCHES–DENTURE STATUS

	ABSENT	PRESENT	DEFECTIVE
UPPER			
LOWER			

WHEN YOU EAT,	YES	NO
DO YOU USE AN UPPER PLATE?		
DO YOU USE A LOWER PLATE?		

REMARKS: PRESENT ____ ABSENT ____

DENTAL EXAMINATION

STAND AND CONTROL

0	1	2	3	4		5	6	7	8	9

TREATMENT NEEDS

NO APPARENT NEED FOR DENTAL CARE

YES	NO	
		REMOVAL OF DEBRIS AND CALCULUS
		GINGIVITIS TREATMENT
		PERIODONTAL DISEASE TREATMENT
		SEVERE MALOCCLUSION TREATMENT
		DECAYED PRIMARY TEETH
		DECAYED PERMANENT TEETH
		EXTRACTIONS, PERIODONTAL DISEASE
		EXTRACTIONS, OTHER
		FIXED BRIDGES AND/OR PARTIAL DENTURES INDICATED REPLACING TEETH NO.'S
		REPAIR OR RELINE OF DENTURE OR BRIDGE
		CONSTRUCT DENTURE(S)

INTERVIEW

DO YOU HAVE ANY TROUBLE;	YES	NO
CHEWING STEAKS, CHOPS OR FIRM MEATS?		
BITING APPLES OR CORN-ON-THE-COB?		
BITING OR CHEWING ANY OTHER FOODS?		

DECAYED PRIMARY TEETH

	0	1	2	3	4		5	6	7	8	9
ONE-SURFACE FILLINGS						TENS / UNITS					
TWO-SURFACE FILLINGS						TENS / UNITS					
THREE (OR MORE)-SURFACE FILLINGS						TENS / UNITS					
EXTRACTIONS						TENS / UNITS					

DECAYED PERMANENT TEETH

	0	1	2	3	4		5	6	7	8	9
ONE-SURFACE FILLINGS						TENS / UNITS					
TWO-SURFACE FILLINGS						TENS / UNITS					
THREE (OR MORE)-SURFACE FILLINGS						TENS / UNITS					
EXTRACTIONS						TENS / UNITS					

	0	1	2	3	4		5	6	7	8	9
EXTRACTIONS, PERIODONTAL DISEASE						TENS / UNITS					
EXTRACTIONS, OTHER						TENS / UNITS					

FIXED BRIDGES AND/OR PARTIAL DENTURES INDICATED REPLACING TEETH NO.'S

UPPER ARCH	1	2	3	4	5	6	7	8
	9	10	11	12	13	14	15	16
LOWER ARCH	17	18	19	20	21	22	23	24
	25	26	27	28	29	30	31	32
NO. OF BRIDGES	1	2	3		4	5	6	
NO. OF PARTIALS	1	2	3		4	5	6	

REPAIR OR RELINE OF DENTURE OR BRIDGE

REPAIR	F.U.	F.L.	P.U.	P.L.
RELINE	F.U.	F.L.	P.U.	P.L.

CONSTRUCT DENTURE(S) F.U. F.L.

Confidentiality has been assured examinees as set forth in 22 F.R. 1687

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

REPORT OF DENTAL FINDINGS

Dear Doctor:

Recently the person named in this report was among those who had voluntary examinations at special mobile facilities operated by the Public Health Service.

The dental examination of the Health and Nutrition Examination Survey is not, and is not intended to be, a substitute for the examination usually given to persons seeking care from their own dentist. Neither a dental history nor X-rays are taken, and therefore the findings are solely the result of what can be seen at the time of the examination. The examinee named in this report requested that it be sent to you.

If you have any questions about the Survey, please write.

Sincerely,

LAWRENCE E. VAN KIRK, D.D.S.
Dental Advisor
Room 8A-54, Parklawn Building
Rockville, Maryland 20852

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

Examinee's name and address	Age	Date of examination

THE INDEX ASSESSMENTS USED IN THE SURVEY REVEAL:

☐ No conditions which suggest that the examinee should be seen by you before the next regular appointment.

☐ **One** or **more** of the **following conditions** that suggest a clinical examination is desirable to determine whether or not treatment is needed before the next regular appointment.

☐ Decayed teeth ☐ Oral debris and/or calculus
☐ Gingivitis and/or periodontal disease ☐ Malocclusion
☐ Other conditions — *Specify* ________

HSM-425-14(B) (PAGE 1)
REV. 8/71

Confidentiality has been assured examinees as set forth in 22 F.R. 1687

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

REPORT OF PHYSICAL FINDINGS[1]

Dear Doctor:

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

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

Sincerely,

Frank Lowenstein

FRANK LOWENSTEIN, M.D.
Nutrition Advisor

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

Examinee's name and address	Date of examination	Age	Height
		Sex	Weight

MEDICAL	DERMATOLOGICAL	OPHTHALMOLOGICAL	VISUAL ACUITY
☐ No new significant findings	☐ No new significant findings	☐ No new significant findings	R Eye 20/___ L Eye 20/___
			☐ Without glasses
			☐ With glasses
			☐ With contacts
			☐ Not tested

		URINE	Neg	Tr	1	2	3	4
Hematocrit	______ vol%	Albumin						
Hemoglobin	______ gm%	Sugar						
RBC count	______ mill/cc	Ph	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	
WBC count	______ thou/cc	Hematest		☐ Pos		☐ Neg		
Sed rate	______ mm/hr							

☐ SEE REVERSE SIDE FOR NOTES ON TESTS AND PROCEDURES

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

NOTES ON TESTS AND PROCEDURES

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

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

Hematology – Screening limits ***

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

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

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

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

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

BLOOD

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

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

HSM 425-5A
REV. 6-71

HEALTH AND NUTRITION EXAMINATION SURVEY

CDC-NUTRITIONAL BIOCHEMICAL LAB. - DATA

CARD	SAMPLE NO.	RACE SEX	AGE		EXAMINATION DATE			HOUR OF COLLECTION		HEMATOCR	HEMOGLOB.
			YEARS	MONTHS	MONTH	DAY	YEAR				
801									1 ☐ AM 2 ☐ PM	___ ___.___%	___ ___.___ GMS %
(1 - 3)	(4 - 8)	(9)	(10 - 11)	(12 - 13)	(14 - 15)	(16 - 17)	(18 - 19)	(20 - 21)	(22)	(23 - 25)	(26 - 28)

Hours since last meal: ____ (29, 30)

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

Has examinee taken within last 30 days: Days

Vitamins (32) 1 ☐ No 2 ☐ Yes → last taken (33, 34) ____

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

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

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

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

Last taken in days (45-46) ____________

Type of prescribed or other medication ____________

____

Physical activity in past 24 hours:

(47) 1 ☐ None 2 ☐ Light 3 ☐ Med. 4 ☐ Heavy

Date shipped ____________

# of blood vials shipped 0 1 2 3 4 5 6 7 8 9 10

# of urine vials shipped 0 1

REMARKS-NURSE	REMARKS-LABORATORY
Factors that might affect nutri'l. stat. at time of exam:	

RACE-SEX CODE

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

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

CONTROL RECORD

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

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

a. Name (*Last, first, middle*)	b. Deck No. 201	c. Sex 1 ☐ Male 2 ☐ Female

d. Date of birth Month / Day / Year	e. Age	f. Examination date (001) Month / Day / Year	g. Temperature (002) ___.__

PROCEDURE	Time IN	Time OUT	NOT DONE	STAFF	Procedure or part of overall procedure not done (*Enter reason for non-completion*)
1. Casual specimen	(003)	(004)	x ☐		
2. Body measurements	(005)	(006)	x ☐		
3. X-rays	(007)	(008)	x ☐		PREGNANT (009) 1 ☐ Yes 2 ☐ No
4. Physician's examination	(010)	(011)	x ☐		
5. Venipuncture	(012)	(013)	x ☐		
6. Tuberculin test	(014)	(015)	x ☐		
7. Dermatology	(016)	(017)	x ☐		
8. Ophthalmology I	(018)	(019)	x ☐		
9. Ophthalmology II	(020)	(021)	x ☐		
10. Dental examination	(022)	(023)	x ☐		
11. Audiometry	(024)	(025)	x ☐		
12. ECG and Spiro	(026)	(027)	x ☐		ECG / SPIRO
13. Lung analyzer	(028)	(029)	x ☐		
14. Goniometry	(030)	(031)	x ☐		
15. Nutrition questionnaire	(032)	(033)	x ☐		IN HOME (034) 1 ☐ Yes 2 ☐ No
16a. Supplement A	(035)	(036)	x ☐		
b. Supplement B	(037)	(038)	x ☐		
c. Supplement C	(039)	(040)	x ☐		
17. Health care needs	(041)	(042)	x ☐		
18. General well-being	(043)	(044)	x ☐		

OFFICE USE ONLY (081) N ☐ (091) N ☐	TIME IN	TIME OUT	Sample Number

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

GENERAL MEDICAL EXAMINATION

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

ASSURANCE OF CONFIDENTIALITY
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Deck No. 232

A. EXTERNAL EAR (Except canal)

	Right	Left
1. No findings – *SKIP to B* . . . . . . 1.	(001) 1 ☐	(002) 1 ☐
2. Findings – *Continue with 3* . . 2.	2 ☐	2 ☐
3. Operative scar . . . 3.	(003) 1 ☐	(004) 1 ☐
4. Other – *Describe* . 4. ______	(005) 1 ☐	(006) 1 ☐
5. Pierced ears . . . . 5.	(007) 1 ☐ Yes	2 ☐ No

B. AUDITORY CANAL

	Right	Left
1. No findings – *SKIP to C* . . . . . . 1.	(008) 1 ☐	(009) 1 ☐
2. Findings – *Continue with 3* . . 2.	2 ☐	2 ☐
3. Occluded: a. Partially . . . . . 3a.	(010) 1 ☐	(011) 1 ☐
b. Completely . . . . b.	2 ☐	2 ☐
4. Occluded by: a. Cerumen . . . . . 4a.	(012) 1 ☐	(013) 1 ☐
b. Other – *Describe* b. ______	2 ☐	2 ☐

C. DRUM

	Right	Left
1. No findings – *SKIP to D* . . . . . . 1.	(014) 1 ☐	(015) 1 ☐
2. Findings – *Continue with 4* . . . 2.	2 ☐	2 ☐
3. Not visible . . . . . 3.	3 ☐	3 ☐
4. Dull (Opaque) . . . . 4.	(016) 1 ☐	(017) 1 ☐
5. Transparent . . . . . 5.	2 ☐	2 ☐
6. Bulging . . . . 6.	(018) 1 ☐	(019) 1 ☐
7. Retracted . . . . . . 7.	2 ☐	2 ☐
8. Calcium plaques . . 8.	(020) 1 ☐	(021) 1 ☐
9. Other findings – *Describe* . . . . 9. ______	(022) 1 ☐	(023) 1 ☐

C. DRUM – Continued

	Right	Left
10. Red . . . . 10.	(024) 1 ☐	(025) 1 ☐
11. Other discolorations 11.	2 ☐	2 ☐
12. Fluid . . . . 12.	(026) 1 ☐	(027) 1 ☐
13. Scars . . . . 13.	(028) 1 ☐	(029) 1 ☐
14. Perforated a. With discharge 14a.	(030) 1 ☐	(031) 1 ☐
b. Without discharge . b.	2 ☐	2 ☐

D. NARES

	Right	Left
1. No findings – *SKIP to E* . . . . . . 1.	(032) 1 ☐	(033) 1 ☐
2. Findings – *Continue with 3* . . 2.	2 ☐	2 ☐
3. Obstruction a. Acute . . . . 3a.	(034) 1 ☐	(035) 1 ☐
b. Chronic . . . . . . b.	2 ☐	2 ☐
4. Other significant findings – a. Deviated septum . 4a.	(036) 1 ☐	(037) 1 ☐
b. Swollen turbinates b.	(038) 1 ☐	(039) 1 ☐
c. Chronic inflammation c.	(040) 1 ☐	(041) 1 ☐
d. Other –*Describe* . d. ______	(042) 1 ☐	(043) 1 ☐

E. NECK

1. No findings – *SKIP to F* . . . . . . 1.	(044) 1 ☐
2. Findings – *Continue with 3* . . 2.	2 ☐
3. Adenopathy . . . . . 3.	(045) 1 ☐
4. Tracheal deviation. 4.	(046) 1 ☐
5. Other – *Describe*. . 5. ______	(047) 1 ☐

Sample Number

F. CHEST

1. Auscultation

(048) 1 ☐ No findings – *SKIP to G*

2 ☐ Findings →

	Dimin. brth. sounds	Absent b.s.	Bronchial b.s.	Rales	Rhonchi	Wheeze
Right chest Upper lobe	(049) 1 ☐	2 ☐	(050) 1 ☐	(051) 1 ☐	(052) 1 ☐	(053) 1 ☐
Middle lobe	(054) 1 ☐	2 ☐	(055) 1 ☐	(056) 1 ☐	(057) 1 ☐	(058) 1 ☐
Lower lobe	(059) 1 ☐	2 ☐	(060) 1 ☐	(061) 1 ☐	(062) 1 ☐	(063) 1 ☐
Left chest Upper lobe	(064) 1 ☐	2 ☐	(065) 1 ☐	(066) 1 ☐	(067) 1 ☐	(068) 1 ☐
Lower lobe	(069) 1 ☐	2 ☐	(070) 1 ☐	(071) 1 ☐	(072) 1 ☐	(073) 1 ☐

2. Other chest findings

(074) 1 ☐ None   2 ☐ Findings ______________________

G. HEART

1. P.M.I. . . . . 1. (075) 1 ☐ Felt   2 ☐ Not felt

2. Interspace . . . . 2. (076) 4 ☐ 5 ☐ 6 ☐ 7 ☐

3. Midclavicular line . . . . 3. (077) 1 ☐ At   2 ☐ Inside   3 ☐ Outside

4. Thrills . . . . 4. (078) 1 ☐ Absent   2 ☐ Present

a. Systolic . . . . a. (079) 1 ☐ Base   2 ☐ Apex

b. Diastolic . . . . b. (080) 1 ☐ Base   2 ☐ Apex

5. Heart sounds

a. 1st heart sound . . . . 5a. (081) 1 ☐ Normal   2 ☐ Accentuated   3 ☐ Diminished

b. 2nd heart sound . . . . b. (082) 1 ☐ Normal   2 ☐ Accentuated   3 ☐ Diminished

6. Murmurs . . . . 6. (083) 1 ☐ None – *Skip to 7*

		SYSTOLIC MURMUR(S)	DIASTOLIC MURMUR(S)
a. Type	a.	(084) 1 ☐ Functional 2 ☐ Organic 9 ☐ Don't know	(085) 1 ☐ Functional 2 ☐ Organic 9 ☐ Don't know
b. Location		GRADE	GRADE
(1) Apex	b(1)	(086) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	(087) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐
(2) Midprecordium	(2)	(088) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	(089) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐
(3) Left base	(3)	(090) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	(091) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐
(4) Right base	(4)	(092) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐	(093) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Continue with 6c, "Origin" on Page 3

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G. HEART – Continued

6. Murmurs – Continued

c. Origin

			Systolic	Diastolic	Both
(1) Mitral	6c.(1)	094	1 ☐	2 ☐	3 ☐
(2) Aortic	(2)	095	1 ☐	2 ☐	3 ☐
(3) Tricuspid	(3)	096	1 ☐	2 ☐	3 ☐
(4) Pulmonic	(4)	097	1 ☐	2 ☐	3 ☐
(5) ASD	(5)	098	1 ☐	2 ☐	3 ☐
(6) VSD	(6)	099	1 ☐	2 ☐	3 ☐
(7) Other	(7)	100	1 ☐	2 ☐	3 ☐
(8) Don't know	(8)	101	9 ☐		

7. Other cardiac or cardiovascular findings — (102) 1 ☐ No – *Skip to H* 2 ☐ Yes – *Continue with 7a*

a. Edema . . . . 7a. (103) 1 ☐

b. Other – *Describe* . . . . b. (104) 1 ☐

____

____

c. Neck vein distension . . . . c. (105) 1 ☐

H. PULSE – ARTERIAL EVALUATION

1. Palpation

			Normal	Sclerotic	Tortuous	Sclerotic and Tortuous
a. Right radial	1a.	106	1 ☐	2 ☐	3 ☐	4 ☐
b. Right femoral	b.	107	1 ☐	2 ☐	3 ☐	4 ☐
c. Right dorsalis pedis	c.	108	1 ☐	2 ☐	3 ☐	4 ☐
d. Left radial	d.	109	1 ☐	2 ☐	3 ☐	4 ☐
e. Left femoral	e.	110	1 ☐	2 ☐	3 ☐	4 ☐
f. Left dorsalis pedis	f.	111	1 ☐	2 ☐	3 ☐	4 ☐

2. Pulsations

			Normal	Diminished	Bounding	Absent
a. Right radial	2a.	112	1 ☐	2 ☐	3 ☐	4 ☐
b. Right femoral	b.	113	1 ☐	2 ☐	3 ☐	4 ☐
c. Right dorsalis pedis	c.	114	1 ☐	2 ☐	3 ☐	4 ☐
d. Other – *Describe*	d.	115	1 ☐	2 ☐	3 ☐	4 ☐
e. Left radial	e.	116	1 ☐	2 ☐	3 ☐	4 ☐
f. Left femoral	f.	117	1 ☐	2 ☐	3 ☐	4 ☐
g. Left dorsalis pedis	g.	118	1 ☐	2 ☐	3 ☐	4 ☐
h. Other – *Describe*	h.	119	1 ☐	2 ☐	3 ☐	4 ☐

____

____

Sample Number

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I. KNEES

(120) 1 ☐ Findings – *Continue with 1*
2 ☐ No findings – *Skip to J*

1. Bony irregularity		R	L	Both
a. Genu varum . . . . 1a.	(121)	1 ☐	2 ☐	3 ☐
b. Genu valgum . . . . b.	(122)	1 ☐	2 ☐	3 ☐
c. Genu recurvatum . . . . c.	(123)	1 ☐	2 ☐	3 ☐
d. Fixed flexion . . . . d.	(124)	1 ☐	2 ☐	3 ☐
e. Other – *Describe* . . . . e.	(125)	1 ☐	2 ☐	3 ☐

____

2. Pain on motion		Act.	Pas.	Both		Tenderness
a. Right medial . . . . 2a.	(126)	1 ☐	2 ☐	3 ☐	(127)	1 ☐
b. Right lateral . . . . b.	(128)	1 ☐	2 ☐	3 ☐	(129)	1 ☐
c. Right diffuse . . . . c.	(130)	1 ☐	2 ☐	3 ☐	(131)	1 ☐
d. Left medial . . . . d.	(132)	1 ☐	2 ☐	3 ☐	(133)	1 ☐
e. Left lateral . . . . e.	(134)	1 ☐	2 ☐	3 ☐	(135)	1 ☐
f. Left diffuse . . . . f.	(136)	1 ☐	2 ☐	3 ☐	(137)	1 ☐
g. Right suprapatellar . . . . g.	. . . .				(138)	1 ☐
h. Left suprapatellar . . . . h.	. . . .				(139)	1 ☐
i. Right infrapatellar . . . . i.	. . . .				(140)	1 ☐
j. Left infrapatellar . . . . j.	. . . .				(141)	1 ☐

3. Other findings		R	L	Both
a. Swelling . . . . 3a.	(142)	1 ☐	2 ☐	3 ☐
b. Fluid . . . . b.	(143)	1 ☐	2 ☐	3 ☐
c. Soft tissue proliferation . . . . c.	(144)	1 ☐	2 ☐	3 ☐
d. Subpatellar crepitus . . . . d.	(145)	1 ☐	2 ☐	3 ☐
e. Muscular wasting thigh . . . . e.	(146)	1 ☐	2 ☐	3 ☐
f. Other – *Describe* . . . . f.	(147)	1 ☐	2 ☐	3 ☐

____

J. HIPS

(148) 1 ☐ Findings – Continue with 1
2 ☐ No findings – *Skip to K*

1. Pain on motion		ACTIVE R	ACTIVE L	ACTIVE Both		PASSIVE R	PASSIVE L	PASSIVE Both
a. Extension . . . . 1a.	(149)	1 ☐	2 ☐	3 ☐	(150)	1 ☐	2 ☐	3 ☐
b. Flexion . . . . b.	(151)	1 ☐	2 ☐	3 ☐	(152)	1 ☐	2 ☐	3 ☐
c. Abduction . . . . c.	(153)	1 ☐	2 ☐	3 ☐	(154)	1 ☐	2 ☐	3 ☐
d. Adduction . . . . d.	(155)	1 ☐	2 ☐	3 ☐	(156)	1 ☐	2 ☐	3 ☐
e. Ext. rot . . . . e.	(157)	1 ☐	2 ☐	3 ☐	(158)	1 ☐	2 ☐	3 ☐
f. Int. rot . . . . f.	(159)	1 ☐	2 ☐	3 ☐	(160)	1 ☐	2 ☐	3 ☐

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J. HIPS – Continued

1. Other findings

		R	L	Both
a. Muscle wasting (gluteal)	1a.	(161) 1 ☐	2 ☐	3 ☐
b. Trochanter tenderness	b.	(162) 1 ☐	2 ☐	3 ☐
c. Groin tenderness	c.	(163) 1 ☐	2 ☐	3 ☐
d. Other – *Describe* ______________		(164) 1 ☐	2 ☐	3 ☐

K. JOINTS

(165) 1 ☐ No findings – *Skip to L*
2 ☐ Findings – *Describe and continue with 1* ______________

Other joints	MANIFESTATIONS													
	Tender		Swelling		Deformity		Limitation		Heberden's nodes		Pain on motion		Other	
1. Shoulder	(166) 1 ☐R 3 ☐B 2 ☐L		(167) 1 ☐R 3 ☐B 2 ☐L		(168) 1 ☐R 3 ☐B 2 ☐L		(169) 1 ☐R 3 ☐B 2 ☐L				(170) 1 ☐R 3 ☐B 2 ☐L		(171) 1 ☐R 3 ☐B 2 ☐L	
2. Elbow	(172) 1 ☐R 3 ☐B 2 ☐L		(173) 1 ☐R 3 ☐B 2 ☐L		(174) 1 ☐R 3 ☐B 2 ☐L		(175) 1 ☐R 3 ☐B 2 ☐L				(176) 1 ☐R 3 ☐B 2 ☐L		(177) 1 ☐R 3 ☐B 2 ☐L	
3. Wrist	(178) 1 ☐R 3 ☐B 2 ☐L		(179) 1 ☐R 3 ☐B 2 ☐L		(180) 1 ☐R 3 ☐B 2 ☐L		(181) 1 ☐R 3 ☐B 2 ☐L				(182) 1 ☐R 3 ☐B 2 ☐L		(183) 1 ☐R 3 ☐B 2 ☐L	
	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT			RIGHT	LEFT	RIGHT	LEFT
4. Metacarpo-phalangeal (No. involved)	(184) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(185) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(186) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(187) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(188) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(189) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(190) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(191) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐			(192) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(193) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(194) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(195) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
5. Proximal-inter-phalangeal (No. involved)	(196) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(197) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(198) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(199) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(200) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(201) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(202) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(203) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐			(204) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(205) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(206) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(207) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
									RIGHT	LEFT				
6. Distalinter-phalangeal (No. involved)	(208) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(209) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(210) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(211) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(212) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(213) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(214) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(215) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(216) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(217) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(218) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(219) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(220) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	(221) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
7. Ankle	(222) 1 ☐R 3 ☐B 2 ☐L		(223) 1 ☐R 3 ☐B 2 ☐L		(224) 1 ☐R 3 ☐B 2 ☐L		(225) 1 ☐R 3 ☐B 2 ☐L				(226) 1 ☐R 3 ☐B 2 ☐L		(227) 1 ☐R 3 ☐B 2 ☐L	
8. Feet	(228) 1 ☐R 3 ☐B 2 ☐L		(229) 1 ☐R 3 ☐B 2 ☐L		(230) 1 ☐R 3 ☐B 2 ☐L		(231) 1 ☐R 3 ☐B 2 ☐L				(232) 1 ☐R 3 ☐B 2 ☐L		(233) 1 ☐R 3 ☐B 2 ☐L	

L. BACK

(234) 1 ☐ No findings – *Skip to M*
2 ☐ Findings – *Continue with 1*

1. Scoliosis .... 1. (235) 1 ☐
2. Kyphosis .... 2. (236) 1 ☐
3. Lordosis .... 3. (237) 1 ☐
4. Tenderness
   a. Sciatic notch .... 4a. (238) 1 ☐ R 2 ☐ L 3 ☐ Both
   b. Sacroiliac .... b. (239) 1 ☐ R 2 ☐ L 3 ☐ Both
   c. Other – *Describe* (240) 1 ☐

   ____

   ____

5. Limitation of motion
   a. Cervical spine ...... 5a. (241) 1 ☐
   b. Thoracic spine ...... b. (242) 1 ☐
   c. Lumbar spine flexion . . c. (243) 1 ☐
   d. Lumbar spine, right lateral flexion ..... d. (244) 1 ☐
   e. Lumbar spine, left lateral flexion .... e. (245) 1 ☐
   f. Full extension ...... f. (246) 1 ☐
6. Pain on motion .... 6. (247) 1 ☐ Negative 2 ☐ Positive

	Cervical	Thoracic	Low back	Diffuse	Uncertain
7. Flexion .... 7.	(248) 1 ☐	(249) 1 ☐	(250) 1 ☐	(251) 1 ☐	(252) 1 ☐
8. Extension .... 8.	(253) 1 ☐	(254) 1 ☐	(255) 1 ☐	(256) 1 ☐	(257) 1 ☐
9. Right lateral bending ... 9.	(258) 1 ☐	(259) 1 ☐	(260) 1 ☐	(261) 1 ☐	(262) 1 ☐
10. Left lateral bending .... 10.	(263) 1 ☐	(264) 1 ☐	(265) 1 ☐	(266) 1 ☐	(267) 1 ☐
11. Right rotation .... 11.	(268) 1 ☐	(269) 1 ☐	(270) 1 ☐	(271) 1 ☐	(272) 1 ☐
12. Left rotation .... 12.	(273) 1 ☐	(274) 1 ☐	(275) 1 ☐	(276) 1 ☐	(277) 1 ☐

M. STRAIGHT-LEG-RAISING TEST

1. Right leg .... 1. (278) 1 ☐ Neg. 2 ☐ Pos.
2. Left leg .... 2. (280) 1 ☐ Neg. 2 ☐ Pos.
3. Increase –
   a. On ankle (right leg) . . . 3a. (279) 1 ☐ Yes 2 ☐ No
   b. Dorsiflexion (Left leg) (281) 1 ☐ Yes 2 ☐ No

N. OTHER SYSTEMS
(Reticulo endothelial, G.I., etc.)

(282) 1 ☐ No findings – Skip to O
2 ☐ Findings – *Describe* →

____

____

____

____

____

Sample Number

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O. BLOOD PRESSURE

		TIME		SYSTOLIC	DIASTOLIC
1. Recumbent . . . . 1.	(283)	__ : __	1 ☐ A.M.	(284) ___	(285) ___
2. Sitting . . . . 2.			2 ☐ P.M.	(287) ___	(288) ___

P. SUMMARY OF DIAGNOSTIC IMPRESSIONS

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

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

Name of physician	Sample Number

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HSM-425-8
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS
HEALTH AND NUTRITION EXAMINATION SURVEY

GONIOMETRY

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

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

Deck No.	Examiner No.	Recorder No.
261	__ __	

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

NOTES

Sample Number

HSM-425-9
REV. 11/71

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

RESPIRATORY FUNCTION TESTS

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

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

Deck No.	Room temperature
251	(001) __ __ °C

▶ A. SPIROMETER

1. Was test satisfactory? . . . . 1. (002) 1 ☐ Yes 2 ☐ No – *Explain*

____

____

▶ B. SINGLE BREATH DIFFUSING CAPACITY

1. Inspired Co. 1. 1 0 0%
2. Small spirometer temperature . . . . 2. (003) __ __ °C
3a. Uncorrected barometric pressure . . . . 3a. (004) __ __ __ . __ mm. Hg.
b. Barometer temperature . . . . b. (021) __ __ °C

		TRIAL #1	TRIAL #2	TRIAL #3
4. Inspired helium	4.	(005) __ __ . __ __	(010) __ __ . __ __	(015) __ __ . __ __
5. Expired helium percent	5.	(006) __ . __ __	(011) __ . __ __	(016) __ . __ __
6. Expired Co meter reading	6.	(007) __ __ . __	(012) __ __ . __	(017) __ __ . __
7. Breath holding time *cm	7.	(008) __ __ . __	(013) __ __ . __	(018) __ __ . __
8. Volume inspired V.C. (ATPS) ml	8.	(009) __ __ __ __	(014) __ __ __ __	(019) __ __ __ __

9. Was test satisfactory? . . . . 9. (020) 1 ☐ Yes 2 ☐ No – *Explain*

____

* From tracing – ½ inspiration point measured to onset of expiration

NOTES

Sample Number

HSM-425-10
REV. 11/71

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

AUDIOMETRY

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

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

Deck No.	Audio No.	Examiner No.
241	(001) _ _ _ _ _	(002) _ _

START HERE IF SAMPLE NO. EVEN

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

START HERE IF SAMPLE NO. ODD

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

Condition affecting test results (*Check only one*)

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

____

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

** *Specify frequencies affected and describe* ______________________

____

____

____

Sample Number

HSM-425-2
REV. 11/71

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

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

T B SKIN TEST

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

Name (*Last, first, middle*)	Deck No. 221
Tuberculin administrator	Date (*Month, day, year*) __ __ __

1. Site injected	1.	(001) 1 ☐ Volar forearm 2 ☐ Other ______
2. Millimeter induration a. PPD–S (L.A.)	2a.	(002) __ __
b. PPD–B (R.A.)	b.	(003) __ __
3. Reader	3.	______
4. Date read	4.	(004) Month __ __ Day __ __ Year __ __
5. Where read?	5.	(005) 1 ☐ Home 2 ☐ Work 3 ☐ Exam center 4 ☐ Other

NOTES

Sample Number

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE
NATIONAL CENTER FOR HEALTH STATISTICS
ROCKVILLE, MD. 20852

HEALTH AND NUTRITION EXAMINATION SURVEY

REPORT OF PHYSICAL FINDINGS

Dear Doctor:

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

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

Sincerely,

Arnold Engel

Arnold Engel, M.D.
Medical Advisor

Examinee's name and address ▶ ______ ______	Date of examination	Age / Sex	Height / Weight	Chest X-ray ☐ Encl. ☐ Not done	EKG ☐ Encl. ☐ Not done

MEDICAL	DERMATOLOGICAL	OPHTHALMOLOGICAL	VISUAL ACUITY
☐ *No new significant findings*	☐ *No new significant findings*	☐ *No new significant findings*	R Eye 20/__ L Eye 20/__
______	______	______	☐ Without glasses
______	______	______	☐ With glasses
______	______	______	☐ With contacts
			☐ Not tested

Hematocrit ______ vol %
Hemoglobin ______ gm %
RBC count ______ mill/cc
WBC count ______ thou/cc
Sed rate ______ mm/hr

URINE	Neg	Tr	1	2	3	4
Albumin						
Sugar						
Ph	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	
Hematest		☐ Pos		☐ Neg		

Tuberculin

PPD-S ______ mm Not done ______
PPD-B ______ mm Not read ______

Audiogram – Decibels				
CPS	500	1000	2000	4000
Right				
Left				

Sample Number

☐ ***SEE REVERSE SIDE FOR NOTES ON TESTS AND PROCEDURES***

NOTES ON TESTS AND PROCEDURES

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

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

Hematology – Screening limits *

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

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

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

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

ROUGH GUIDELINES FOR dB REPORT AT 500 – 2000 cps.

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

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

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

BLOOD

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

*U.S. GOVERNMENT PRINTING OFFICE : 1979 0-281-259

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