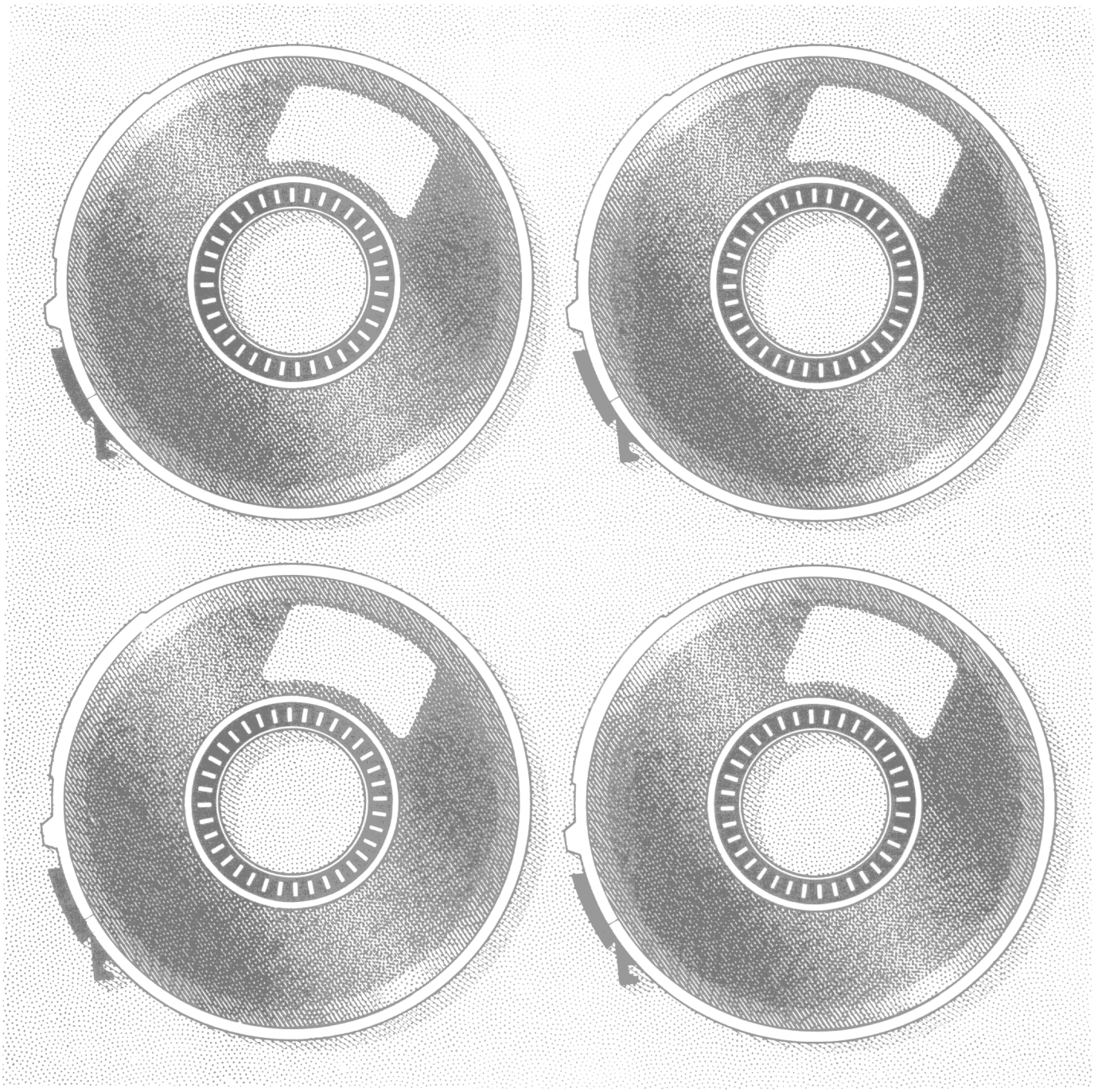
Public Use Data Tape Documentation

Physician's Examination
Ages 6 Months - 74 Years
Tape Number 6509

Version 2

Hispanic Health and Nutrition
Examination Survey, 1982-1984

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • Centers for Disease Control • National Center for Health Statistics



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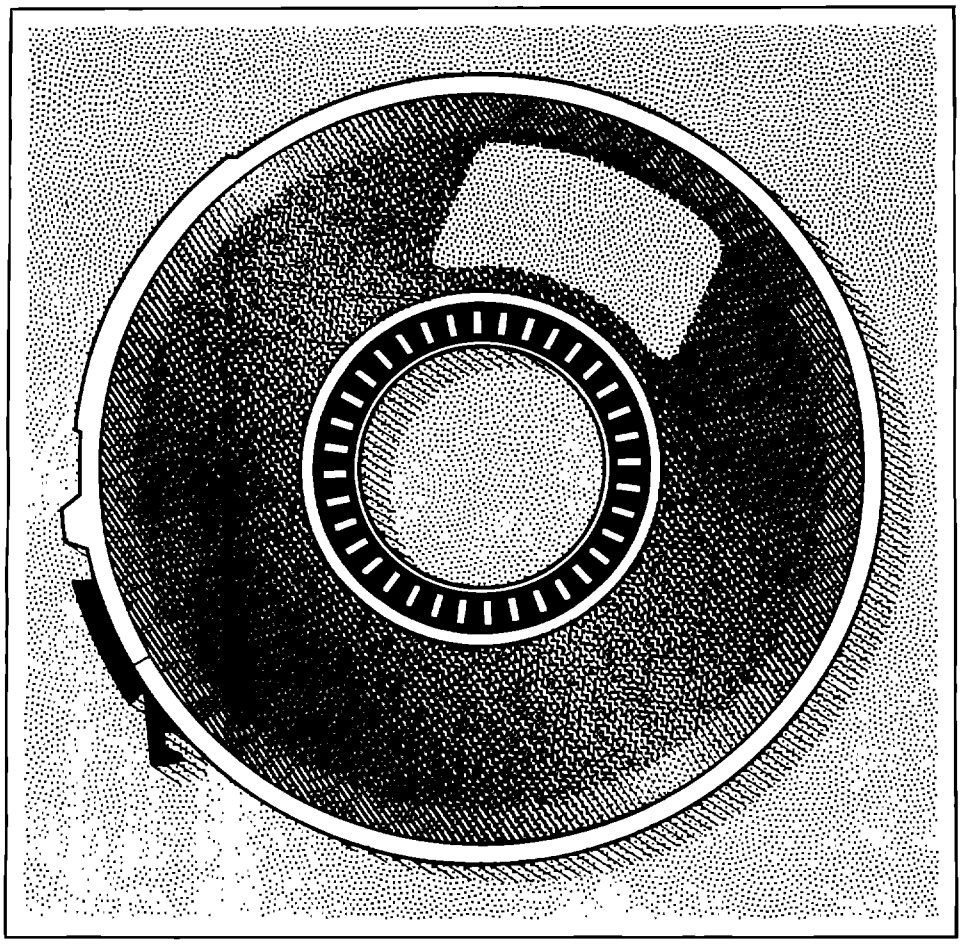

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
National Center for Health Statistics

Hyattsville, Maryland
November 1988

Hispanic Health and Nutrition Examination Survey

Mexican Americans
Cuban Americans
Puerto Ricans

Tape Number 6509

PHYSICIAN'S EXAMINATION

Ages 6 Months - 74 Years

Version 2

January 1987

The Hispanic Health and Nutrition Examination Survey (HHANES) was conducted from July 1982 through December 1984. The data on the tape documented here are from all three portions of the survey:

Mexican Americans
Residing in selected counties of Texas, Colorado, New Mexico, Arizona, and California
Surveyed from July 1982 through November 1983
9,894 persons sampled; 8,554 interviewed; 7,462 examined

Cuban Americans
Residing in Dade County (Miami), Florida
Surveyed from January 1984 through April 1984
2,244 persons sampled; 1,766 interviewed; 1,357 examined

Puerto Ricans
Residing in the New York City area, including parts of New Jersey and Connecticut
Surveyed from May 1984 through December 1984
3,786 persons sampled; 3,369 interviewed; 2,834 examined

The following tape characteristics are those of the version of the tape kept at NCHS and of the tape transmitted to the National Technical Information Service for release to users:

Tape labels: IBM standard
Data set name: HHANES.DU650902
Data set organization: Physical sequential
Record format: Fixed block
Record length: 860
Block size: 24080
Density: 6250 BPI
Number of records: 11653
Data code: EBCDIC

CAUTION

BEFORE USING THIS DATA TAPE,
PLEASE READ THIS PAGE

- Read the accompanying description of the survey, "The Plan and Operation of the Hispanic Health and Nutrition Examination Survey", DHHS Publication No. (PHS) 85-1321 before conducting analyses of the data on this tape.

- Two aspects of HHANES, especially, should be taken into account when conducting any analyses: the sample weights and the complex survey design.

- Analyses should not be conducted on data combined from the three portions of the survey (Mexican-American, Cuban-American, Puerto Rican).

- HHANES is a survey of Hispanic households and some of the sample persons included on this tape are not of Hispanic origin. A detailed description of the data codes dealing with national origin or ancestry appears in the NOTES section of this document.

- Examine the range and frequency of values of a variable before conducting an analysis of data. The range may include unusual or unexpected values. The frequency counts may be useful to determine which analyses may be worthwhile.

- Language of Interview, which may appear several places on this tape, can vary depending on the questionnaire (several used in the survey) and on whether the response was provided by the sample person or by a proxy.

- For some data items, reference is made to a note. The notes (in a separate section of this document) may be very important in data analyses. Attention to them is strongly urged.

This Public Use Data Tape has been edited very carefully. Numerous consistency and other checks were also performed. Nevertheless, due especially to the large number of data items, some errors may have gone undetected.

Please bring to the attention of NCHS any errors in the data tape or the documentation. Errata sheets will be sent to people who have purchased the data tapes and corrections will be made to subsequently released data tapes.

In publications, please acknowledge NCHS as the original data source. The acknowledgment should include a disclaimer crediting the authors for analyses, interpretations, and conclusions; NCHS should be cited as being responsible for only the collection and processing of the data. In addition, NCHS requests that the acronym HHANES be placed in the abstracts of journal articles and other publications based on data from this survey in order to facilitate the retrieval of such materials through automated bibliographic searches. Please send reprints of journal articles and other publications that include data from this tape to NCHS.

Division of Health Examination Statistics
National Center for Health Statistics
Center Building, Room 2-58
3700 East-West Highway
Hyattsville, MD 20782

Public Use Data Tapes for the Hispanic Health and Nutrition Examination Survey will be released through the National Technical Information Service (NTIS) as soon as the data have been edited, validated, and documented. A list of NCHS Public Use Data Tapes that can be purchased from NTIS may be obtained by writing the Scientific and Technical Information Branch, NCHS.

Scientific and Technical Information Branch
National Center for Health Statistics
Center Building, Room 1-57
3700 East-West Highway
Hyattsville, MD 20782
301-436-8500

CONTENTS

SECTION A. INTRODUCTION AND SURVEY DESCRIPTION

The National Center for Health Statistics (NCHS) collects, analyzes, and disseminates data on the health status of Americans. The results of surveys, analyses, and studies are made known primarily through publications and the release of computer data tapes. This document contains details required to guide programmers, statistical analysts, and research scientists in the use of a Public Use Data Tape.

From 1960 through 1980 NCHS conducted five population-based, national health examination surveys. Each survey involved collecting data by direct physical examination, the taking of a medical history, and laboratory and clinical tests and measurements. Questionnaires and examination components have been designed to obtain and support analyses of data on certain targeted conditions such as diabetes, hypertension, and anemia. Beginning with the first National Health and Nutrition Examination Survey (NHANES I) a nutrition component was added to obtain information on nutritional status and dietary practices. The numbers of Hispanics in these samples were, however, insufficient to enable adequate estimation of their health conditions. From 1982 through 1984 a Hispanic Health and Nutrition Examination Survey (HHANES) was conducted to obtain data on the health and nutritional status of three Hispanic groups: Mexican Americans from Texas, Colorado, New Mexico, Arizona, and California; Cuban Americans from Dade County, Florida; and Puerto Ricans from the New York City area, including parts of New Jersey and Connecticut.

The general structure of the HHANES sample design was similar to that of the previous National Health and Nutrition Examination Surveys. All of these studies have used complex, multistage, stratified, clustered samples of defined populations. The major difference between HHANES and the previous surveys is that HHANES was a survey of three special subgroups of the population in selected areas of the United States rather than a national probability sample. A detailed presentation of the design specifications is found in Chapter 5 of "Plan and Operation of the Hispanic Health and Nutrition Examination Survey, 1982-84" (Ref. No. 1).

Data collection began with a household interview. Several questionnaires were administered:

- A Household Screener Questionnaire (HSQ), administered at each selected address, for determining household eligibility and for selecting sample persons.
- A Family Questionnaire (FQ), administered once for each family containing sample persons, which included sections on family relationships, basic demographic information for sample persons and head of family, Medicare and health insurance coverage, participation in income assistance programs, and housing characteristics.
- An Adult Sample Person Questionnaire (ASPQ), for persons 12 through 74 years which, depending on age, included sections on health status measures, health services utilization, smoking (20 through 74 years), meal program participation, and acculturation. Information on the use of medicines and vitamins in the past two weeks was also obtained.
- A Child Sample Person Questionnaire (CSPQ), for sample persons 6 months through 11 years which included sections on a number of health status issues, health care utilization, infant feeding practices, participation in meal programs, school attendance, and language use. Information on the use of medicines and vitamins in the past two weeks was also obtained.

At the Mobile Examination Center two questionnaires were administered and an examination performed:

- An Adult Sample Person Supplement (ASPS), for sample persons 12 through 74 years, which included sections on alcohol consumption, drug abuse, depression, smoking (12 through 19 years), pesticide exposure, and reproductive history.

- A Dietary Questionnaire (DQ), for persons 6 months through 74 years, by which trained dietary interviewers collected information about "usual" consumption habits and dietary practices, and recorded foods consumed 24-hours prior to midnight of the interview.

- An examination which included a variety of tests and procedures. Age at interview and other factors determined which procedures were administered to which examinees. A dentist performed a dental examination and a vision test. Technicians took blood and urine specimens and administered a glucose tolerance test, X-rays, electrocardiograms, and ultrasonographs of the gallbladder. Technicians also performed hearing tests and took a variety of body measurements. A physician performed a medical examination focusing especially on the cardiovascular, gastrointestinal, neurological, and musculoskeletal systems. The physician's impression of overall health, nutritional and weight status, and health care needs were also recorded. Some blood and urine specimen analyses were performed by technicians in the examination center; others were conducted under contract at various laboratories.

Because the HHANES sample is not a simple random one, it is necessary to incorporate sample weights for proper analysis of the data. These sample weights are a composite of individual selection probabilities, adjustments for noncoverage and nonresponse, and poststratification adjustments. The HHANES sample weights, which are necessary for the calculation of point estimates, are located on all data tapes in positions 184-213. Because of the complex sample design and the ratio adjustments used to produce the sample weights, commonly used methods of point and variance estimation and hypothesis testing which assume simple random sampling may give misleading results. In order to provide users with the capability of estimating the complex sample variances in the HHANES data, Strata and Pseudo Primary Sampling Unit (PSU) codes have been provided on all data tapes in positions 214-217. These codes and the sample weights are necessary for the calculation of variances.

There are computer programs available designed for variance estimation for complex sample designs. The balanced repeated replication approach (Ref. No. 2) is used in &REPERR and a linearization approach is used in &PSALMS to calculate variance-covariance matrixes. Both routines are available within the OSIRIS IV library (Ref. No. 3). SURREGR (Ref. No. 4) and SUPERCARP (Ref. No. 5) are programs that calculate variance-covariance matrixes using a linearization approach (Ref. No. 6) (Taylor series expansion). Another program, SESUDAAN (Ref. No. 7) calculates standard errors, variances, and design effects. (Note: This version of SESUDAAN should not be used to obtain variances for totals.) SURREGR and SESUDAAN are special procedures which run data under the SAS system (Ref. No. 8).

Even though the total number of examined persons in this survey is quite large, subclass analyses can lead to estimates that are unstable, particularly estimates of variances. Consequently, analyses of subclasses require that the user pay particular attention to the number of sample persons in the subclass and the number of PSU's that contain at least one sample person in the subclass. Small sample sizes, or a small number of PSU's used in the variance calculations, may produce unstable estimates of the variances.

A more complete discussion of these issues and possible analytic strategies for examining various hypotheses is presented in Chapter 11 of "Plan and Operation of the Hispanic Health and Nutrition Examination Survey, 1982-84" (Ref. No. 1) and in an earlier NCHS methodology (Series 2) publication (Ref. No. 9).

Some users, however, may not have access to the computer programs for estimating complex sample variances or may want to do their preliminary analyses without using them. In addition, variance estimates calculated from HHANES data through use of the programs described previously are likely to be unstable because there were so few sample areas for each portion of HHANES. This instability is not due to there being too few people in the sample but may be due to the fact that the sample was selected from relatively few areas. Therefore, the following discussion is designed to provide an alternative approach to deal with the unavailability of software and the small number of PSU s. The approach is based on using average design effects (Ref. No. 10).

The design effect, defined as the ratio of the variance of a statistic from a complex sample to the variance of the same statistic from a simple random sample of the same size, that is,

$$\text{DESIGN EFFECT (DEFF)} = \frac{\text{COMPLEX SAMPLE VARIANCE}}{\text{SIMPLE RANDOM SAMPLE VARIANCE}}$$

is often used to show the impact of the complex sample design on variances. If the design effect is near 1, the complex sample design has little effect on the variances and the user could consider assuming simple random sampling for the analysis.

Some illustrative design effects for HHANES data on this tape are given in the following tables. The design effects in the tables are the average for the age groups usually presented in NCHS Series 11 publications. If the average design effect for a subgroup was less than 1.0 (implying an improvement over simple random sampling), it was coded as 1.0.

The following guidelines were used in the calculation of the average design effects:

1. Exclude all persons of non-Hispanic origin,
2. Exclude all estimates for large age ranges, such as all ages combined or 'all adults', and
3. Exclude all estimates where the proportion of the subpopulation with the specific characteristic or condition was zero percent or one hundred percent.

Design effects tend to be larger when age groups are combined, just as they are when the sexes are combined, as shown in the tables. The data in the tables give the user an idea of the range in design effects for selected response variables from this data tape. If a response variable is not one shown in the tables take the range into account; it is possible that a user could have one of the higher, rather than one of the lower, design effects.

Average Design Effects, by Sex, for Selected Variables
Mexican-American Portion

Physician's Examination	Mean or Proportion	Tape Positions	Both Sexes	Male	Female
Left Tympanic Membrane Scar(s)	p	444	3.4	2.1	2.2
Strabismus	p	465	5.3	3.1	3.4
Surgical Scars on Abdomen	p	599	1.1	1.0	1.1
Right Hip Limitation of Motion (10+ years)	p	675	2.2	1.6	1.3
Pulse (all ages)	p	778-780	3.8	2.5	2.5
Systolic Blood Pressure (6+ years)	$\bar{x}$	783-785	2.9	2.3	1.8
Diastolic Blood Pressure (6- years)	$\bar{x}$	786-788	2.3	2.0	1.6
Scoliosis (5+ years)	p	790	5.2	3.3	3.2
Right Dosalis Pedis Pulse (Presence/Absence)	p	657	1.7	1.3	1.3

Source: NCHS, HHANES, 1982-84, Tape Number 6509, Version 2.

Average Design Effects, by Sex, for Response Variables
Cuban-American Portion

Physician's Examination	Mean or Proportion	Tape Positions	Both Sexes	Male	Female
Left Tympanic Membrane Scar(s)	p	444	1.0	1.0	1.0
Strabismus	p	465	1.0	1.0	1.0
Surgical Scars on Abdomen	p	599	1.4	1.0	1.5
Right Hip Limitation of Motion (10+ years)	p	675	1.1	1.0	1.0
Pulse (all ages)	p	778-780	1.4	1.3	1.1
Systolic Blood Pressure (6+ years)	$\bar{x}$	783-785	1.5	1.1	1.2
Diastolic Blood Pressure (6+ years)	$\bar{x}$	786-788	1.0	1.0	1.1
Scoliosis (5+ years)	p	790	1.1	1.0	1.3
Right Dosalis Pedis Pulse (Presence/Absence)	p	657	1.0	1.0	1.2

Source: NCHS, HHANES, 1982-84, Tape Number 6509, Version 2.

Average Design Effects, by Sex, for Selected Variables
Puerto Rican Portion

Physican's Examination	Mean or Proportion	Tape Positions	Both Sexes	Male	Female
Left Tympanic Membrane Scar(s)	p	444	1.3	1.2	1.1
Strabismus	p	465	1.3	1.1	1.2
Surgical Scars on Abdomen	p	599	1.0	1.0	1.1
Right Hip Limitation of Motion (10+ years)	p	675	1.2	1.2	1.0
Pulse (all ages)	p	778-780	1.1	1.0	1.0
Systolic Blood Pressure (6+ years)	$\bar{x}$	783-785	1.1	1.8	1.2
Diastolic Blood Pressure (6+ years)	$\bar{x}$	786-788	1.1	1.5	1.3
Scoliosis (5+ years)	p	790	1.6	1.0	1.5
Right Dosalis Pedis Pulse (Presence/Absence)	p	657	1.4	1.3	1.1

Source: NCHS, HHANES, 1982-84, Tape Number 6509, Version 2.

A hypothetical example will be given for illustrative purposes only. Suppose there are 850 Mexican-American females in the sample 30-64 years old, of whom 8.4 percent had scoliosis and their mean systolic blood pressure was 124.

Assuming simple random sampling, the variance for the percent is calculated by converting the percent to a proportion and using the standard formula for the variance of a proportion,

$$V = \frac{pq}{n}$$

This variance (V) multiplied by the design effect (DEFF) provides an estimate of the variance from a complex sample of the same sample size (n). In the example above,

$$V = \frac{(.084)\ (.916)}{850}$$

$$= .00009 = \text{variance for a simple random sample}$$

Then, multiplying by the design effect,

$$= (.00009)\ (3.2)$$

$$= .00029 = \text{estimated variance for the complex sample}$$

In a similar way, the complex sample variance of the mean systolic blood pressure for this age-sex group is determined by multiplying the simple random sample variance of the mean by the appropriate design effect -- in this example, 1.8.

The user can then proceed with estimating confidence intervals and testing hypotheses in the usual manner.

The user should recognize that this approach does not incorporate the variance covariance matrix. In most cases, this leads to a slight overestimate of the variance because the covariance terms, which are subtracted in the variance of a ratio, in general are positive. Thus, in a borderline case, the null hypothesis would be less likely to be rejected (Ref. No. 11).

Alternative or better approaches may exist or be developed. Users who want to suggest such approaches, or who want the latest information should contact the Scientific and Technical Information Branch (address given in the beginning of this documentation).

SECTION B. DATA COLLECTION AND PROCESSING PROCEDURES

Data presented in Sections E through H and the family relationships data in Section J were collected on the Household Screener and Family Questionnaires. These interview schedules were administered in sample persons' households. Data presented in Section K were collected during the physical examination which was administered in the mobile examination center. Completed interview and examination forms were reviewed in the Survey's field offices and again at the data processing center of NCHS by clerical editors. The editors checked the forms for completeness, clarity, and compliance with skip patterns, and they coded items such as industry and occupation. At the data processing center the data were keyed and verified on key-to-disk data entry equipment under the control of programs that checked for valid codes and ranges, compliance with skip patterns, and consistency. After being keyed, data were reedited by analysts for reasonableness and consistency and for compliance with instructions for sampling and questionnaire administration.

The general tape description format is Tape Position X Item X Counts. The item (field) may be a tape descriptor (e.g. Version Number), a sample person descriptor (e.g. Age at Interview), or a question (e.g. Is sample person covered by Medicare?). Where appropriate, data entries are presented by codes. Frequency counts are given for each code. The counts are included to help the user in planning analyses and in verifying that programs account for all data. The data source is given also (e.g., from Family Questionnaire). In some cases, a note is referenced. The notes contain explanations of the item (e.g. how Poverty Index is calculated).

The questionnaire data have undergone many quality control and editing procedures. The responses of sample persons to some questions may appear extreme or illogical. Self-reported data, especially, are subject to a number of sources of variability, including recall and other reporting errors. In the data clean-up process, responses that varied considerably from expected were verified through direct review of the collection form or a copy of it. Such responses may not represent fact, but they are included as recorded in the field. The user must determine if these responses should be included in analyses.

Responses to "other" and "specify" were recoded to existing categories, if possible. For responses that could not be recoded, new code categories were created if the information was deemed analytically useful. Caution should be used in interpreting the data from these new categories because there is no way of knowing which other respondents would have selected one of the new categories if given the option.

For the physician's examination tape there are three codes for missing information: 7's, 8's, and blanks. In a few questions, 7's were used when the question was not applicable. A code "8", which is labeled as "blank but applicable", is used to indicate that a sample person should have a data value for a particular item but for varying reasons that value is unavailable. Blanks were used to follow skip patterns, i.e., when a question was not supposed to be asked or was not applicable.

The physician's examination data give an objective measure of the health and well-being of individuals examined in HHANES. The physicians underwent extensive training to standardize the techniques and definitions used in the physician's examination. Periodic monitoring ensured that the established procedures were followed throughout the survey. The Appendix contains a description of the techniques and definitions used in the physician's examination. It is taken from the Physician's Examination Manual for the Hispanic Health and Nutrition Examination Survey, 1982-84 (Ref. No. 12). However, examiner differences are likely to remain. The user should identify relevant examiner differences before beginning their analyses.

At the completion of the physical examination, the physician recorded a subset of the medical conditions diagnosed based on data collected in the physical examination and the Sample Person Questionnaire. The physician listed all medical conditions which fulfilled any one of the three following conditions:

- Potentially or presently life threatening,
- Causing loss of functioning and/or limitation of activity for at least the previous three months, or
- On a potentially downward course.

The conditions listed were coded using the Ninth Revision of the International Classification of Diseases.

The physician also decided on a level of referral for the sample person. The levels of referral were:

- Level I - emergency
- Level II - needs major medical care within one month
- Level III - no major medical findings.

Copies of the questionnaires, both in English and Spanish, can be found in the plan and operation report for HHANES (Ref. No. 1). Detailed information on interviewing and examination procedures is contained in the household interviewer's manual (Ref. No. 13), and the mobile examination center interviewer's manual (Ref. No. 14), and the physician's examination manual (Ref. No. 12). These manuals are available upon request from:

Division of Health Examination Statistics
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3700 East-West Highway
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301-436-7080

SECTION C. REFERENCES

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12. National Center for Health Statistics: Instruction Manual Part 15e, Physician's Examination Manual for the Hispanic Health and Nutrition Examination Survey, 1982-84. Hyattsville, MD, 1985.

13. National Center for Health Statistics: Instruction Manual Part 15h, Household Interviewer's Manual for the Hispanic Health and Nutrition Examination Survey, 1982-84. Hyattsville, MD, 1986.

14. National Center for Health Statistics: Instruction Manual Part 15g, Mobile Examination Center Interviewer's Manual for the Hispanic Health and Nutrition Examination Survey, 1982-84. Hyattsville, MD, 1986.

SECTION D. TAPE POSITION INDEX

TAPE POSITIONS 1-400 contain data categories common to all data tapes: sociodemographic data, family composition, family income, residence and household. Sample weights are also in this set of data.

TAPE POSITIONS 401+ contain data categories unique to this data tape.

SOCIODEMOGRAPHIC DATA - SAMPLE PERSON (SECTION E)

1-5	Sample Person Sequence Number
6-15	Survey and Tape Identifiers
16	Examination Status
17	Language of Interview
18-21	Date of Interview
22-25	Date of Examination
26-29	Date of Birth
30-32	Age at Interview
33-38	Age at Examination
39-43	Family Number
44-45	Relationship to Head of Family
46	Sex
47	Race
48-49	National Origin or Ancestry
50-52	Birth Place
53	National Origin Recode
54-56	Education
57	Marital Status
58	Service in Armed Forces
59-69	Work/Occupation/Employment
70-95	Health Insurance/Health Care Support
96-99	Income Assistance/Public Compensation or Support

SOCIODEMOGRAPHIC DATA - HEAD OF FAMILY (SECTION F)

100	Interview and Examination Status
102-105	Date of Birth
106-108	Age at Interview
109	Sex
110	Race
111-112	National Origin or Ancestry
113-115	Birth Place
116-118	Education
119	Marital Status
120	Service in Armed Forces
121-131	Work/Occupation/Employment

FAMILY COMPOSITION AND INCOME DATA (SECTION G)

132-133	Number of People in Family
134-135	Number of Sample People in Family
136-138	Combined Family Income
139-143	Per Capita Income
144-146	Poverty Index
147-162	Income, Food Stamps

RESIDENCE AND HOUSEHOLD DATA (SECTION H)

163	Size of Place
164	Standard Metropolitan Statistical Area
165-166	Number of People in Household
167-168	Number of Sample People in Household
169-170	Number of Rooms
171	Kitchen Facilities Access
172-183	Heating/Cooling Equipment

SAMPLE WEIGHTS (SECTION I)

184-189	Examination Final Weight
190-195	Interview Final Weight
196-201	GTT/Ultrasound Weight
202-207	Audiometry/Vision Weight
208-213	Pesticide Weight
214-215	Strata Code
216-217	Pseudo PSU Code

FAMILY RELATIONSHIPS (SECTION J)

218-400	Data not yet available

PHYSICIAN EXAMINATION DATA (SECTION K)

401-404	Tape Number
406	Physician's Examination Form Blank
410-412	Examiner Number
420-448	Skull and Ears
450-459	Nares
461-463	Lips and Pharynx
465-498	Eyes
500-504	Neck
506-516	Pulse and Blood Pressure
518-565	Chest Findings and CVA Tenderness
568-569	Breast Mass(es)
571-597	Heart
599-642	Abdomen
644-647	Gallbladder Questions
648-650	Tanner Staging
652-666	Extremities
669-741	Joints
743-756	Neurological Evaluation
759-776	Skin Evaluation
778-788	Pulse and Blood Pressure
790-805	Back
806-808	Gait
809-810	Varicose Veins
812-814	Health Status
815-855	ICD Codes
856	Level of Referral

Position	Item description and code	Counts M	C	P	Source and notes
SECTION E. SOCIODEMOGRAPHIC DATA - SAMPLE PERSON (POS 1-99)	Source: Family Questionnaire (FQ) Household Screener Questionnaire (HSQ)				
1-5	**Sample person sequence number**				
	00001-09894 Mexican Americans	7462	-	-	
	10002-12238 Cuban Americans	-	1357	-	
	13001-16785 Puerto Ricans	-	-	2834	
6-12	**Blank**				
13	**Portion of survey**				
	1 Mexican-American (M)	7462	-	-	
	2 Cuban-American (C)	-	1357	-	
	3 Puerto Rican (P)	-	-	2834	
14	**Family Questionnaire missing**				
	1 Yes	21	6	10	See Note 1
	2 No	7441	1351	2824	
15	**Version number**				
	2	7462	1357	2834	
16	**Examination status**				
	1 Examined	7462	1357	2834	See Note 2
	2 Not examined	0	0	0	
17	**Language of interview (Pos. 1-400)**				FQ
	1 English	4513	244	1229	
	2 Spanish	2929	1107	1595	
	Blank	20	6	10	
	Date of interview				HSQ 4
18-19	01-12 Month	7462	1357	2834	
20-21	82-84 Year	7462	1357	2834	
	Date of examination From survey control record				
22-23	01-12 Month	7462	1357	2834	
24-25	82-84 Year	7462	1357	2834	
	Date of birth				HSQ 2e
26-27	01-12 Month	7462	1357	2834	
	88 Blank but applicable	0	0	0	
28-29	08-84 Year	7462	1357	2834	
	88 Blank but applicable	0	0	0	
30-31	**Age at interview (computed)** 01-74 (See next column for units)	7462	1357	2834	
32	**Age at interview units**				HSQ 2f
	1 Years	7342	1349	2796	
	2 Months	120	8	38	

Position	Item description and code	Counts M	Counts C	Counts P	Source and notes
	Age at examination (computed) Positions 33-38 are all 0 for non-examined persons.				
33-34	00-75 Years	7462	1357	2834	
35-36	00-11 Months	7462	1357	2834	
37-38	00-30 Days	7462	1357	2834	
39-43	**Family number**				See Note 3
	00002-03529	7462	-	-	
	04005-04922	-	1357	-	
	07001-08584	-	-	2834	
44-45	**What is sample person's relationship to head of family? Sample person is:**				HSQ 2b See Note 4
	01 Head of family living alone (1 family with only 1 member)	145	56	113	
	02 Head of family, with no related persons in household (2+ persons in household)	76	23	24	
	03 Head of family, with related persons in household	1582	369	676	
	04 Wife of head (husband living at home and not in Armed Forces)	1299	300	296	
	05 Wife of head (husband living at home and is in Armed Forces)	5	0	0	
	06 Husband of head (wife living at home and not in Armed Forces)	35	12	37	
	07 Husband of head (wife living at home and is in Armed Forces)	0	0	0	
	08 Child of head or head's spouse	3769	484	1437	
	09 Grandchild of head or head's spouse	217	32	115	
	10 Parent of head or head's spouse	57	35	33	
	11 Other relative (includes ex-spouse, daughter-in-law, etc.)	273	46	101	
	12 Foster child	4	0	0	
46	**Sex**				FQ B-4
	1 Male	3516	636	1237	
	2 Female	3946	721	1597	
47	**Observed race**				FQ B-5
	1 White	7213	1300	2462	See Note 5
	2 Black	76	15	152	
	3 Other	8	3	73	
	8 Blank but applicable	72	15	59	
	9 Not observed	72	18	78	
	Blank	21	6	10	
48-49	**Sample person's national origin or ancestry.**				HSQ 2c See Note 6
	01 Mexican/Mexicano	1641	1	1	
	02 Mexican-American	5202	0	0	
	03 Chicano	102	0	0	
	04 Puerto Rican	7	3	2596	
	05 Boricuan	0	0	36	
	06 Cuban	4	1069	20	
	07 Cuban-American	0	222	0	
	08 Hispano - specify	150	14	26	
	09 Other Latin-American or other Spanish - specify	37	18	41	
	00 Other - specify	276	30	114	
	10 Spanish-American	22	0	0	
	11 Spanish (Spain)	21	0	0	

Position	Item description and code	Counts W	C	P	Source and notes
50-52	**In what state or foreign country was sample person born?**				FQ B-6 See Note 7
	001-118 State/country code	7403	1345	2771	
	888 Blank but applicable	38	6	53	
	Blank	21	6	10	
53	**National origin recode** "Hispanic" = Mexican-American in Southwest, Cuban-American in Florida and Puerto Rican in New York City area				See Note 8
	1 "Hispanic"	7197	1291	2645	
	2 Not "Hispanic"	265	66	189	
54-55	**What is the highest grade or year of regular school sample person has ever attended?**				FQ B-7
	00 Never attended or kindergarten only	1476	116	446	
	01-08 Elementary grade	3118	556	1090	
	09-12 High school grade	2119	400	1011	
	13-16 College	581	243	225	
	17 Graduate school	70	30	14	
	88 Blank but applicable	77	6	36	
	Blank	21	6	10	
56	**Did sample person finish that grade/year?**				FQ B-8
	1 Yes	3938	853	1436	
	2 No	1934	368	861	
	8 Blank but applicable	93	14	81	
	Blank	1497	122	456	
57	**Is sample person now married, widowed, divorced, separated or has he or she never been married?**				FQ B-9
	0 Under 14 years of age	2953	297	1000	
	1 Married - spouse in household	2600	632	660	
	2 Married - spouse not in household	70	17	54	
	3 Widowed	161	50	66	
	4 Divorced	214	92	155	
	5 Separated	159	21	149	
	6 Never married	1265	241	730	
	8 Blank but applicable	19	1	10	
	Blank	21	6	10	
58	**Did sample person ever serve in the Armed Forces of the United States?**				FQ B-11
	1 Yes	416	27	145	
	2 No	3557	952	1409	
	8 Blank but applicable	7	3	14	
	Blank	3482	375	1266	
59	**During the past 2 weeks, did sample person work at any time at a job or business, not counting work around the house?**				FQ B-12
	1 Yes	2210	622	613	
	2 No	1751	349	930	
	8 Blank but applicable	19	11	25	
	Blank	3482	375	1266	

Position	Item description and code	Counts M	C	P	Source and notes
60	**Even though sample person did not work during those 2 weeks, did he or she have a job or business?**				FQ B-13
	1 Yes	46	13	23	
	2 No	1704	334	902	
	8 Blank but applicable	20	13	30	
	Blank	5692	997	1879	
61	**Was sample person looking for work or on layoff from a job?**				FQ B-14
	1 Yes	217	43	60	
	2 No	1533	304	865	
	8 Blank but applicab..	20	13	30	
	Blank	5692	997	1879	
62	**Which, looking for work or on layoff from a job or both?**				FQ B-15
	1 Looking	146	34	44	
	2 Layoff	46	6	8	
	3 Both	23	2	7	
	8 Blank but applicable	22	14	31	
	Blank	7225	1301	2744	
63-65	**What kind of business or industry does sample person work for?**				FQ B-19 See Note 9
	010-932 Industry code	2429	665	681	
	990 Blank but applicable	49	18	37	
	Blank	4984	674	2116	
66-68	**What kind of work was sample person doing?**				FQ B-20 See Note 9
	003-889 Occupation code	2432	666	681	
	999 Blank but applicable	46	17	37	
	Blank	4984	674	2116	
69	**Class of worker**				FQ B-22
	1 An employee of a private company, business or individual for wages, salary, or commission	1912	543	551	
	2 A Federal government employee	74	6	21	
	3 A State government employee	124	19	17	
	4 A Local government employee	169	17	56	
	5 Self-employed in own incorporated business or professional practice	17	12	7	
	6 Self-employed in own unincorporated business, professional practice, or farm	131	67	27	
	7 Working without pay in family business or farm	3	0	0	
	8 Blank but applicable	46	18	38	
	0 Never worked or never worked at a full-time civilian job lasting 2 weeks or more	2	1	1	
	Blank	4984	674	2116	
70	**Is sample person now covered by Medicare?**				FQ C-2
	1 Covered	303	107	139	
	2 Not covered	7129	1237	2674	
	8 Blank but applicable	6	6	11	
	9 Don't know	3	1	0	
	Blank	21	6	10	

Position	Item description and code	Counts M	C	P	Source and notes
71	**Is sample person now covered by the part of Social Security Medicare which pays for hospital bills?**				FQ C-3
	1 Yes	270	100	124	
	2 No	18	4	5	
	8 Blank but applicable	15	6	20	
	9 Don't know	6	3	1	
	Blank	7153	1244	2684	
72	**Is sample person now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which he or she or some agency must pay a certain amount each month.**				FQ C-4
	1 Yes	269	100	111	
	2 No	17	5	17	
	8 Blank but applicable	15	6	20	
	9 Don't know	8	2	2	
	Blank	7153	1244	2684	
73	**Type of Medicare coverage** As shown on Medicare card				FQ C-5
	1 Hospital	0	0	0	
	2 Medical	2	0	0	
	3 Card not available	3	0	2	
	4 Hospital and medical	5	3	0	
	8 Blank but applicable	15	6	20	
	Blank	7437	1348	2812	
	HEALTH INSURANCE				See Note 10
74	**Is sample person covered by any health insurance plan which pays any part of a hospital, doctor's, or surgeon's bill?**				FQ C-11
	1 Yes	4094	818	1011	
	2 No	3326	526	1796	
	8 Blank but applicable	13	7	16	
	9 Don't know	8	0	1	
	Blank	21	6	10	
75	**Is sample person covered by a plan that pays any part of hospital expenses?**				FQ C-9
	1 Yes	4039	806	955	
	2 No	6	7	9	
	8 Blank but applicable	54	12	55	
	9 Don't know	8	0	8	
	Blank	3355	532	1807	
76	**Is sample person covered by a plan that pays any part of a doctor's or surgeon's bills for operations?**				FQ C-10
	1 Yes	4034	804	945	
	2 No	22	11	28	
	8 Blank but applicable	36	10	35	
	9 Don't know	15	0	19	
	Blank	3355	532	1807	

Position	Item description and code	M	Counts C	P	Source and notes
	Many people do not carry health insurance for various reasons. Which of these statements describes why sample person is not covered by any health insurance (or Medicare)? (Positions 77-80)				FQ C-13/15 See Note 10
77-78	**Main reason**				
	01 Care received through Medicaid or welfare	267	31	854	
	02 Unemployed, or reasons related to unemployment	350	40	114	
	03 Can't obtain insurance because of poor health, illness, or age	24	2	15	
	04 Too expensive, can't afford health insurance	1767	280	506	
	05 Dissatisfied with previous insurance	50	3	3	
	06 Don't believe in insurance	31	4	8	
	07 Have been healthy, not much sickness in the family, haven't needed health insurance	206	23	31	
	08 Military dependent, (CHAMPUS), Veteran's benefits	45		15	
	09 Some other reason - not specified	2	0	7	
	10 Some other reason - specified	255	35	58	
	88 Blank but applicable	118	34	77	
	Blank	4347	904	1146	
79-80	**Second reason**				
	00 No second reason reported	2573	339	1374	
	01 Care received through Medicaid or welfare	70	17	58	
	02 Unemployed, or reasons related to unemployment	109	30	30	
	03 Can't obtain insurance because of poor health, illness, or age	4	2	3	
	04 Too expensive, can't afford health insurance	168	20	132	
	05 Dissatisfied with previous insurance	15	1	2	
	06 Don't believe in insurance	18	3	3	
	07 Have been healthy, not much sickness in the family, haven't needed health insurance	47	4	8	
	08 Military dependent, (CHAMPUS), Veteran's benefits	0	0	2	
	09 Some other reason - not specified	0	0	0	
	10 Some other reason - specified	25	8	7	
	88 Blank but applicable	86	29	69	
	Blank	4347	904	1146	
81-87	**Blank**				
88	**During the last 12 months, has sample person received health care which has been or will be paid for by Medicaid?**				FQ D-6
	1 Yes	537	101	1076	
	2 No	6858	1242	1708	
	8 Blank but applicable	45	7	40	
	9 Don't know	0	1	0	
	Blank	21	6	10	

Position	Item description and code	Counts M	Counts C	Counts P	Source and notes
89	**Does sample person have a Medicaid card?**				FQ D-8
	1 Yes	530	104	1144	
	2 No	6872	1232	1647	
	8 Blank but applicable	39	15	33	
	9 Don't know	0	0	0	
	Blank	21	6	10	
90	**Status of sample person's Medicaid card?**				FQ D-9
	1 Medicaid card seen - current	382	84	832	
	2 Medicaid card seen - expired	7	0	12	
	3 No card seen	128	17	274	
	4 Other card seen	0	0	0	
	5 Other card seen (specify)	5	0	2	
	8 Blank but applicable	47	16	57	
	Blank	6893	1238	1657	
91	**Is sample person now covered by any other public assistance program that pays for health care?**				FQ D-11
	1 Yes	54	2	29	
	2 No	7376	1348	2780	
	8 Blank but applicable	11	1	15	
	9 Don't know	0	0	0	
	Blank	21	6	10	
92	**Does sample person now receive military retirement payments from any branch of the Armed Forces or a pension from the Veteran's Administration? Do not include VA disability compensation.**				FQ D-13
	1 Yes	56	4	9	
	2 No	7373	1346	2806	
	8 Blank but applicable	12	1	9	
	9 Don't know	0	0	0	
	Blank	21	6	10	
93	**Which does sample person receive; the Armed Forces retirement, the VA pension, or both?**				FQ D-14
	1 Armed Forces	16	0	2	
	2 Veteran's Administration	30	0	5	
	3 Both	4	4	1	
	8 Blank but applicable	18	1	10	
	Blank	7394	1352	2816	
94	**Is sample person now covered by CHAMP-VA, which is medical insurance for dependents or survivors of disabled veterans?**				FQ D-16
	1 Yes	45	4	10	
	2 No	7388	1346	2808	
	8 Blank but applicable	8	1	6	
	9 Don't know	0	0	0	
	Blank	21	6	10	
95	**Is sample person now covered by any other program that provides health care for military dependents or survivors of military persons?**				FQ D-18
	1 Yes	41	4	8	
	2 No	7387	1346	2804	
	8 Blank but applicable	13	1	12	
	9 Don't know	0	0	0	
	Blank	21	6	10	

Position	Item description and code	Counts M	C	P	Source and notes
96	**Is sample person included in the AFDC, "Aid to Families with Dependent Children", assistance payment?**				FQ D-2
	1 Yes	394	39	650	
	2 No	7020	1304	2134	
	8 Blank but applicable	27	6	39	
	9 Don't know	0	2	1	
	Blank	21	6	10	
97	**Does sample person now receive the "Supplemental Security Income" or "SSI" gold-colored check?**				FQ D-4
	1 Yes	131	44	135	
	2 No	7285	1295	2659	
	8 Blank but applicable	25	12	30	
	9 Don't know	0	0	0	
	Blank	21	6	10	
98	**Does sample person have a disability related to his or her service in the Armed Forces of the United States?**				FQ D-2C
	1 Yes	48	2	14	
	2 No	346	20	108	
	8 Blank but applicable	29	8	37	
	Blank	7039	1327	2675	
99	**Does sample person now receive compensation for this disability from the Veteran's Administration?**				FQ D-21
	1 Yes	31	1	9	
	2 No	17	1	4	
	8 Blank but applicable	29	8	38	
	Blank	7385	1347	2783	

Position	Item description and code	Counts M	Counts C	Counts P	Source and notes
SECTION F. SOCIODEMOGRAPHIC DATA - HEAD OF FAMILY (POS 100-131)					
	Source: Family Questionnaire (FQ) Household Screener Questionnaire (HSQ)				See Note 4
100	**Interview and examination status of head of family**				
	1 Selected as sample person, interviewed on Adult Sample Person Questionnaire, and examined	5523	1076	2098	
	2 Selected as sample person, interviewed on Adult Sample Person Questionnaire, but not examined	338	62	79	
	3 Selected as sample person, not interviewed, and not examined	218	34	23	
	4 Not selected as sample person	1362	179	624	
	Blank	21	6	10	
101	**Blank**				
	Date of birth				HSQ 2e
102-103	01-12 Month	7413	1348	2830	
	88 Blank but applicable	49	9	4	
104-105	00-86, 89-99 Year	7440	1353	2832	
	88 Blank but applicable	22	4	2	
106-107	**Age at interview**				
	17-95 Years	7462	1357	2834	
108	**Blank**				
109	**Sex**				FQ B-4
	1 Male	5982	1069	1331	
	2 Female	1460	282	1493	
	Blank	20	6	10	
110	**Observed race**				FQ B-5
	1 White	7138	1282	2511	See Note 5
	2 Black	75	27	165	
	3 Other	6	3	58	
	8 Blank but applicable	106	31	59	
	9 Not observed	117	8	31	
	Blank	20	6	10	
111-112	**Head of family's national origin or ancestry.**				HSQ 2c See Note 6
	01 Mexican/Mexicano	2068	0	3	
	02 Mexican-American	4523	0	0	
	03 Chicano	97	0	0	
	04 Puerto Rican	19	7	2503	
	05 Boricuan	0	0	29	
	06 Cuban	6	1197	46	
	07 Cuban-American	0	85	2	
	08 Hispano - specify	147	20	37	
	09 Other Latin-American or other Spanish - specify	54	17	39	
	00 Other - specify	513	31	175	
	10 Spanish-American	17	0	0	
	11 Spanish (Spain)	18	0	0	

Position	Item description and code	Counts M	Counts C	Counts P	Source and notes
113-115	**In what state or foreign country was head of family born?**				FQ B-6 See Note 7
	001-118 State/country code	7362	1331	2762	
	888 Blank but applicable	80	20	62	
	Blank	20	6	10	
116-117	**What is the highest grade or year of regular school head of family has ever attended?**				FQ B-7
	00 Never attended or kindergarten only	250	7	35	
	01-08 Elementary grade	2959	511	889	
	09-12 High school grade	2896	411	445	
	13-16 College	1002	336	163	
	17 Graduate school	170	57	41	
	88 Blank but applicable	165	29	51	
	Blank	20	6	10	
118	**Did head of family finish that grade/year?**				FQ B-8
	1 Yes	5710	1171	2210	
	2 No	1316	137	492	
	8 Blank but applicable	166	36	87	
	Blank	270	13	45	
119	**Is the head of family now married, widowed, divorced, separated or has he or she never been married?**				FQ B-9
	0 Under 14	0	0	0	
	1 Married - spouse in household	5706	1059	1295	
	2 Married - spouse not in household	129	9	129	
	3 Widowed	333	48	133	
	4 Divorced	492	136	376	
	5 Separated	388	28	452	
	6 Never married	320	56	418	
	8 Blank but applicable	74	15	21	
	Blank	20	6	10	
120	**Did head of family ever serve in the Armed Forces of the United States?**				FQ B-11
	1 Yes	1478	64	383	
	2 No	5883	1265	2400	
	8 Blank but applicable	81	22	41	
	Blank	20	6	10	
121	**During the past 2 weeks, did head of family work at any time at a job or business, not counting work around the house?**				FQ B-12
	1 Yes	5443	1019	1283	
	2 No	1923	305	1504	
	8 Blank but applicable	76	27	37	
	Blank	20	6	10	
122	**Even though head of family did not work during those 2 weeks, did he or she have a job or business?**				FQ B-13
	1 Yes	101	19	28	
	2 No	1822	286	1476	
	8 Blank but applicable	76	27	37	
	Blank	5463	1025	1293	

Position	Item description and code	Counts M	C	P	Source and notes
123	**Was head of family looking for work or on layoff from a job?**				FQ B-14
	1 Yes	510	61	118	
	2 No	1413	244	1384	
	8 Blank but applicable	76	27	39	
	Blank	5463	1025	1293	
124	**Which, looking for work or on layoff from a job or both?**				FQ B-15
	1 Looking	270	43	69	
	2 Layoff	151	12	26	
	3 Both	85	3	17	
	8 Blank but applicable	80	30	45	
	Blank	6876	1269	2677	
125-127	**What kind of business or industry does head of family work for?**				FQ B-19 See Note 9
	010-932 Industry code	5980	1080	1395	
	990 Blank but applicable	118	28	62	
	Blank	1364	249	1377	
128-130	**What kind of work was head of family doing?**				FQ B-20 See Note 9
	003-889 Occupation code	5988	1080	1391	
	999 Blank but applicable	110	28	66	
	Blank	1364	249	1377	
131	**Class of worker**				FQ B-22
	1 Employee of a private company, business or individual for wages, salary, or commission	4702	842	1058	
	2 A Federal government employee	219	4	45	
	3 A State government employee	246	12	54	
	4 A Local government employee	359	22	169	
	5 Self-employed in own incorporated business or professional practice	49	25	14	
	6 Self-employed in own unincorporated business, professional practice, or farm	420	171	56	
	7 Working without pay in family business or farm	0	0	0	
	8 Blank but applicable	99	32	60	
	0 Never worked or never worked at a full-time civilian job lasting 2 weeks or more	4	0	1	
	Blank	1364	249	1377	

Position	Item description and code	Counts M	C	P	Source and notes
SECTION G. FAMILY COMPOSITION AND INCOME DATA (POS 132-162)	Source: Family Questionnaire (FQ)				
132-133	**Number of persons in family (computed)**				
	01-18 Persons	7462	1357	2834	
134-135	**Number of sample persons in family (computed)**				
	01-13 Persons	7462	1357	2834	
136	**Was the total combined family income during the past 12 months more or less than $20,000? Include money from jobs, Social Security, retirement income, unemployment payments, public assistance, and so forth. Also include income net from interest, dividends, income from business, farm or rent, and any other money income received.**				FQ E-10
	1 $20,000 or more	2353	536	576	
	2 Less than $20,000	4856	785	2193	
	7 Refused information	31	1	7	
	8 Blank but applicable	202	19	46	
	Blank	20	6	10	
137-138	**Of those income groups, which best represents the total combined family income during the past 12 months? Include wages, salaries, and other items we just talked about. (in dollars)**				FQ E-11
	01 Less than 1,000	40	8	7	
	02 1,000 - 1,999	107	10	33	
	03 2,000 - 2,999	143	25	68	
	04 3,000 - 3,999	182	28	132	
	05 4,000 - 4,999	184	34	250	
	06 5,000 - 5,999	234	45	202	
	07 6,000 - 6,999	312	35	213	
	08 7,000 - 7,999	314	46	169	
	09 8,000 - 8,999	284	42	106	
	10 9,000 - 9,999	263	52	125	
	11 10,000 - 10,999	282	72	139	
	12 11,000 - 11,999	250	47	75	
	13 12,000 - 12,999	296	54	100	
	14 13,000 - 13,999	186	32	64	
	15 14,000 - 14,999	254	25	66	
	16 15,000 - 15,999	208	36	77	
	17 16,000 - 16,999	209	34	51	
	18 17,000 - 17,999	231	37	66	
	19 18,000 - 18,999	333	28	82	
	20 19,000 - 19,999	240	55	79	
	21 20,000 - 24,999	694	148	152	
	22 25,000 - 29,999	585	83	124	
	23 30,000 - 34,999	358	78	92	
	24 35,000 - 39,999	257	64	43	
	25 40,000 - 44,999	192	48	36	
	26 45,000 - 49,999	84	43	30	
	27 50,000 and over	107	55	54	
	77 Refused information	76	10	43	
	88 Blank but applicable	537	77	146	
	Blank	20	6	10	

Position	Item description and code	Counts M	C	P	Source and notes
139-143	**Per capita income** (computed)				See Note 11
	00083-50000 Dollars	6829	1264	2636	
	88888 Blank but applicable	613	87	189	
	Blank	20	6	9	
144-146	**Poverty index** (computed)				See Note 12
	Decimal not shown on tape.				
	0.04-9.78	6829	1264	2636	
	999 Blank but applicable	613	87	189	
	Blank	20	6	9	
147	**Did any member of this family receive any Government food stamps in any of the past 12 months?**				FQ E-12
	1 Yes	1651	234	1344	
	2 No	5783	1115	1474	
	8 Blank but applicable	8	2	6	
	Blank	20	6	10	
148-149	**In how many months of the past 12 months did any member of this family receive food stamps?**				FQ E-13
	01-12 Months	1631	234	1335	
	88 Blank but applicable	28	2	15	
	Blank	5803	1121	1484	
150	**Did this family receive any government food stamps last month?**				FQ E-14
	1 Yes	1345	187	1290	
	2 No	303	47	50	
	8 Blank but applicable	11	2	10	
	Blank	5803	1121	1484	
151-152	**In which month did any member of this family <u>last</u> receive food stamps?**				FQ E-15
	01-12 Month	298	47	50	
	88 Blank but applicable	16	2	10	
	Blank	7148	1308	2774	
153-154	**For how many persons were those food stamps authorized?**				FQ E-16
	01-13 Persons	1641	234	1337	
	88 Blank but applicable	18	2	13	
	Blank	5803	1121	1484	
155-157	**What was the total face value of those food stamps received by this family in that month?**				FQ E-17
	010-520 Dollars	1567	230	1325	
	888 Blank but applicable	92	6	25	
	Blank	5803	1121	1484	
158	**Did this family spend more for food in that month than the value of your food stamps?**				FQ E-18
	1 Yes	1405	194	1279	
	2 No	231	40	64	
	8 Blank but applicable	23	2	7	
	Blank	5803	1121	1484	

Position	Item description and code	Counts M	C	P	Source and notes
159-161	**How much more?**				FQ E-19
	003-880 Dollars	1314	182	1258	
	888 Blank but applicable	114	14	28	
	Blank	6034	1161	1548	
162	**Is your family receiving food stamps at the present time?**				FQ E-20
	1 Yes	1273	175	1269	
	2 No	6153	1171	1542	
	8 Blank but applicable	16	5	13	
	Blank	20	6	10	

Position	Item description and code	Counts M	C	P	Source and notes

SECTION H. RESIDENCE AND HOUSEHOLD DATA (POS 163-183)

Source: Family Questionnaire (FQ)
Household Screener Questionnaire (HSQ)

163	**Size of place**				See Note 13
	1 1 million or more	1049	0	2070	
	2 500,000 - 999,999	844	0	0	
	3 250,000 - 499,999	884	467	0	
	4 100,000 - 249,999	203	364	368	
	5 50,000 - 99,999	1277	70	76	
	6 25,000 - 49,999	785	205	216	
	7 10,000 - 24,999	746	120	79	
	8 200 - 9,999	1003	88	24	
	9 Not in a place	671	43	1	
164	**Standard Metropolitan Statistical Area**				See Note 13
	1 In SMSA, in central city	3707	467	2465	
	2 In SMSA, not in central city	2854	890	369	
	4 Not in SMSA	901	0	0	
165-166	**Number of persons in household**				HSQ 1a
	01-18 Persons	7462	1357	2834	
167-168	**Number of sample persons in household (computed)**				
	01-13 Persons	7462	1357	2834	
169-170	**How many rooms are in this home? Count the kitchen, but not the bathroom.**				FQ E-1
	01-14 Rooms	7433	1350	2816	
	88 Blank but applicable	9	1	8	
	Blank	20	6	10	
171	**Do you have access to complete kitchen facilities in this home; that is, a kitchen sink with piped water, a refrigerator and a range or cookstove?**				FQ E-2
	1 Yes	7136	1315	2548	
	2 No	83	10	18	
	8 Blank but applicable	223	26	258	
	Blank	20	6	10	
172-173	**What is the main fuel used for heating this home?**				FQ E-3 See Note 14
	00 No fuel used	538	231	16	
	01 Oil	4	0	1988	
	02 Natural gas	5955	78	718	
	03 Electricity	604	1027	37	
	04 Bottled gas (propane)	174	2	0	
	05 Kerosene	13	3	0	
	06 Wood	98	3	0	
	07 Coal	0	0	14	
	08 Other, not specified	0	0	2	
	09 Other, specified	11	0	8	
	88 Blank but applicable	45	7	41	
	Blank	20	6	10	

Position	Item description and code	Counts M	C	P	Source and notes
174-175	**What is the main heating equipment for this home?**				FQ E-4 See Note 14
	00 No heating equipment used	538	231	20	
	01 Steam or hot water with radiators or convectors	44	5	1450	
	02 Central warm air furnace with ducts to individual rooms, or central heat pump	2677	542	180	
	03 Built-in electric units (permanently installed in wall, ceiling, or baseboard)	474	323	63	
	04 Floor, wall or pipeless furnace	1598	46	21	
	05 Room heaters with flue or vent, burning oil, gas, or kerosene	805	17	596	
	06 Room heaters without flue or vent, burning oil, gas, or kerosene	847	6	425	
	07 Heating stove burning wood, coal or coke	86	0	9	
	08 Fireplace(s)	91	4	0	
	09 Portable electric heater(s)	139	137	4	
	10 Other, not specified	0	0	0	
	11 Other, specified	114	35	16	
	88 Blank but applicable	1	5	23	
	99 Don't know	26	0	17	
	Blank	20	6	10	
176-177	**Are any other types of equipment used for heating this home?**				FQ E-5 See Note 14
	00 No other heating equipment used	6057	1073	2350	
	01 Steam or hot water with radiators or convectors	0	0	13	
	02 Central warm air furnace with ducts to individual rooms, or central heat pump	11	15	7	
	03 Built-in electric units (permanently installed in wall, ceiling, or baseboard)	24	0	2	
	04 Floor, wall or pipeless furnace	11	0	0	
	05 Room heaters with flue or vent, burning oil, gas, or kerosene	22	0	3	
	06 Room heaters without flue or vent, burning oil, gas, or kerosene	22	1	29	
	07 Heating stove burning wood, coal or coke	70	0	8	
	08 Fireplace(s)	449	8	9	
	09 Portable electric heater(s)	186	18	351	
	10 Other, not specified	4	2	3	
	11 Other, specified	18	2	4	
	88 Blank but applicable	30	1	25	
	Blank	558	237	30	
178-179	**What is the main fuel used by this additional equipment?**				FQ E-6 See Note 14
	00 No fuel used	2	0	2	
	01 Oil	0	0	20	
	02 Natural gas	96	2	27	
	03 Electricity	214	35	345	
	04 Bottled gas (propane)	9	0	1	
	05 Kerosene	2	0	25	
	06 Wood	471	8	11	
	07 Coal	2	0	0	
	08 Other, not specified	0	0	0	
	09 Other, specified	7	0	0	
	88 Blank but applicable	44	2	23	
	Blank	6615	1310	2380	

Position	Item description and code	Counts M	C	P	Source and notes
180-181	**What is the main fuel used for cooking in this home?**				FQ E-7
	00 No fuel used	21	4	4	
	01 Oil	14	0	31	
	02 Natural gas	5899	253	2603	
	03 Electricity	1295	1083	148	
	04 Bottled gas (propane)	182	8	12	
	05 Kerosene	0	0	3	
	06 Wood	0	0	0	
	07 Coal	0	0	0	
	08 Other, not specified	0	0	0	
	09 Other, specified	14	1	0	
	86 Blank but applicable	17	2	23	
	Blank	20	6	10	
182	**Do you have air-conditioning - either individual room units, a central system or evaporative cooling?**				FQ E-8
	1 Yes	3583	1254	653	
	2 No	3845	96	2153	
	8 Blank but applicable	14	1	18	
	Blank	20	6	10	
183	**Which do you have?**				FQ E-9
	1 Individual room unit	1625	583	613	
	2 Central air-conditioning	1233	660	22	
	3 Evaporative cooling	719	6	10	
	8 Blank but applicable	20	6	26	
	Blank	3865	102	2163	

Position	Item description and code	Counts M	C	P	Source and notes
SECTION I. SAMPLE WEIGHTS (POS 184-217)					
184-189	**Examined final weight**				
	000439-002711	7462	-	-	
	000223-000891	-	1357	-	
	000177-002000	-	-	2834	
190-195	**Interview final weight**				
	000447-002096	7462	-	-	
	000176-000604	-	1357	-	
	000175-001220	-	-	2834	
	GTT/ULTRASOUND, AUDIOMETRY/VISION, PESTICIDE WEIGHTS By design, only some of the persons in the sample were included in the GTT/ultrasound, audiometry/vision, and pesticide components of the survey. Tape positions for those persons not part of these subsamples are BLANK.				
196-201	**GTT/ultrasound weight**				
	000843-005302	1777	-	-	
	000469-001685	-	449	-	
	000349-003110	-	-	667	
	Blank	5685	908	2167	
202-207	**Audiometry/vision weight**				
	000507-006283	4431	-	-	
	000223-001600	-	804	-	
	000264-003123	-	-	1759	
	Blank	3031	553	1075	
208-213	**Pesticide weight**				
	000872-005584	2465	-	-	
	000441-001600	-	568	-	
	000343-003117	-	-	1012	
	Blank	4997	789	1822	
214-215	**Strata code**				
	01-08	7462	1357	2834	
216-217	**Pseudo PSU code**				
	01-02	7462	1357	2834	

Position	Item description and code	M	Counts C	P	Source and notes

SECTION J. FAMILY RELATIONSHIPS (POS 218-400)

Source: Adult Sample Person Questionnaire
Family Questionnaire

218-400 **Blank**
Data not yet available.

Position	Item description and code	Counts M	C	P	Source and notes
SECTION K. PHYSICAL EXAMINATION DATA (POS 401-860)	Source. Physician's Examination				
401-404	**Tape number**				
	6509	7462	1357	2834	
405	**Blank**				
406	**Physician's examination form blank**				See Note 15
	1 No physician's examination data were taken. Positions 407-860 are blank.	135	12	70	
	2 Physician's examination data are present.	7327	1345	2764	
407-409	**Blank**				
410-412	**Examiner number**				
	500	175	0	0	
	501	3811	0	0	
	502	3334	647	1039	
	504	0	698	621	
	505	0	0	1057	
	510	7	0	47	
	Blank	135	12	70	
413-419	**Blank**				
	SKULL AND EARS (POSITIONS 420-448)				
420	**Bossing of skull**				
	1 Yes	4	0	0	
	4 No	7311	1343	2758	
	8 Blank but applicable	12	2	6	
	Blank	135	12	70	
421	**Right auditory canal-otitis externa**				
	1 Yes	14	2	5	
	4 No	7302	1339	2750	
	8 Blank but applicable	11	4	9	
	Blank	135	12	70	
422	**Left auditory canal-otitis externa**				
	1 Yes	8	3	3	
	4 No	7308	1338	2752	
	8 Blank but applicable	11	4	9	
	Blank	135	12	70	
423	**Right auditory canal-purulent discharge**				
	1 Yes	6	0	0	
	4 No	7309	1339	2755	
	8 Blank but applicable	12	6	9	
	Blank	135	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
424	**Left auditory canal-purulent discharge**				
	1 Yes	3	1	3	
	4 No	7313	1338	2753	
	8 Blank but applicable	11	6	8	
	Blank	135	12	70	
425	**Right ear drum**				See Note 16
	Blank Visualized or exam not given	6782	1055	2413	
	1 Not visualized, other	378	43	67	
	2 Not visualized, canal completely occluded	301	254	346	
	8 Blank but applicable	1	5	8	
426	**Left ear drum**				See Note 16
	Blank Visualized or exam not given	6851	1060	2408	
	1 Not visualized, other	319	44	76	
	2 Not visualized, canal completely occluded	291	248	342	
	8 Blank but applicable		5	8	
427	**Right ear drum-dull (opaque)**				
	1 Yes	84	9	34	
	4 No	6560	1034	2309	
	8 Blank but applicable	4	5	8	
	Blank	814	309	483	
428	**Left ear drum-dull (opaque)**				
	1 Yes	79	9	46	
	4 No	6634	1039	2291	
	8 Blank but applicable	4	5	9	
	Blank	745	304	488	
429	**Right ear drum-transparent**				
	1 Yes	74	3	15	
	4 No	6570	1040	2328	
	8 Blank but applicable	4	5	8	
	Blank	814	309	483	
430	**Left ear drum-transparent**				
	1 Yes	89	4	21	
	4 No	6624	1044	2317	
	8 Blank but applicable	4	5	8	
	Blank	745	304	488	
431	**Right ear drum-bulging**				
	1 Yes	2	0	6	
	4 No	6642	1043	2337	
	8 Blank but applicable	4	5	8	
	Blank	814	309	483	
432	**Left ear drum-bulging**				
	1 Yes	1	0	11	
	4 No	6712	1048	2327	
	8 Blank but applicable	4	5	8	
	Blank	745	304	488	

Position	Item description and code	Counts M	C	P	Source and notes
433	**Right ear drum-retracted**				
	1 Yes	114	4	16	
	4 No	6529	1039	2327	
	8 Blank but applicable	5	5	8	
	Blank	814	309	483	
434	**Left ear drum-retracted**				
	1 Yes	143	15	33	
	4 No	6569	1033	2305	
	8 Blank but applicable	5	5	8	
	Blank	745	304	488	
435	**Right ear drum-calcium plaques**				
	1 Yes	78	2	24	
	4 No	6566	1041	2318	
	8 Blank but applicable	4	5	9	
	Blank	814	309	483	
436	**Left ear drum-calcium plaques**				
	1 Yes	85	4	20	
	4 No	6628	1044	2317	
	8 Blank but applicable	4	5	9	
	Blank	745	304	488	
437	**Right ear drum-reddened**				
	1 Yes	95	17	30	
	4 No	6549	1026	2312	
	8 Blank but applicable	4	5	9	
	Blank	814	309	483	
438	**Left ear drum-reddened**				
	1 Yes	107	21	30	
	4 No	6607	1027	2307	
	8 Blank but applicable	3	5	9	
	Blank	745	304	488	
439	**Right ear drum-other discoloration**				
	1 Yes	8	0	15	
	4 No	6635	1043	2328	
	8 Blank but applicable	5	5	8	
	Blank	814	309	483	
440	**Left ear drum-other discoloration**				
	1 Yes	11	0	24	
	4 No	6701	1048	2314	
	8 Blank but applicable	5	5	8	
	Blank	745	304	488	
441	**Right ear drum-fluid**				
	1 Yes	20	0	2	
	4 No	6622	1043	2340	
	8 Blank but applicable	6	5	9	
	Blank	814	309	483	

Position	Item description and code	Counts M	C	P	Source and notes
442	**Left ear drum-fluid**				
	1 Yes	30	0	7	
	4 No	6681	1048	2330	
	8 Blank but applicable	6	5	9	
	Blank	745	304	488	
443	**Right ear drum-scars**				
	1 Yes	551	12	36	
	4 No	6091	1031	2307	
	8 Blank but applicable	6	5	8	
	Blank	814	309	483	
444	**Left ear drum-scars**				
	1 Yes	608	16	65	
	4 No	6101	1030	2273	
	8 Blank but applicable	8	5	8	
	Blank	745	304	488	
445	**Right ear drum-perforation with discharge**				
	1 Yes	5	0	3	
	4 No	6638	1043	2340	
	8 Blank but applicable	5	5	8	
	Blank	814	309	483	
446	**Left ear drum-perforation with discharge**				
	1 Yes	9	0	0	
	4 No	6703	1048	2338	
	8 Blank but applicable	5	5	8	
	Blank	745	304	488	
447	**Right ear drum-perforation without discharge**				
	1 Yes	39	0	9	
	4 No	6604	1043	2334	
	8 Blank but applicable	5	5	8	
	Blank	814	309	483	
448	**Left ear drum-perforation without discharge**				
	1 Yes	28	0	11	
	4 No	6684	1048	2327	
	8 Blank but applicable	5	5	8	
	Blank	745	304	488	
449	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
	NARES (POSITIONS 450-459)				
450	**Right nares-obstruction**				
	1 Yes	18	3	3	
	4 No	7281	1339	2749	
	8 Blank but applicable	28	3	12	
	Blank	135	12	70	
451	**Left nares-obstruction**				
	1 Yes	17	5	5	
	4 No	7282	1337	2747	
	8 Blank but applicable	28	3	12	
	Blank	135	12	70	
452	**Right nares-deviated septum**				
	1 Yes	140	19	11	
	4 No	7171	1323	2732	
	8 Blank but applicable	16	3	21	
	Blank	135	12	70	
453	**Left nares-deviated septum**				
	1 Yes	87	14	10	
	4 No	7223	1326	2733	
	8 Blank but applicable	17	3	21	
	Blank	135	12	70	
454	**Right nares-swollen turbinates**				
	1 Yes	224	5	22	
	4 No	7086	1337	2684	
	8 Blank but applicable	17	3	58	
	Blank	135	12	70	
455	**Left nares-swollen turbinates**				
	1 Yes	234	4	25	
	4 No	7075	1338	2681	
	8 Blank but applicable	18	3	58	
	Blank	135	12	70	
456	**Right nares-inflammation**				
	1 Yes	114	4	5	
	4 No	7197	1338	2701	
	8 Blank but applicable	16	3	58	
	Blank	135	12	70	
457	**Left nares-inflammation**				
	1 Yes	121	8	10	
	4 No	7189	1334	2696	
	8 Blank but applicable	17	3	58	
	Blank	135	12	70	
458	**Right nares-polyps**				
	1 Yes	5	1	3	
	4 No	7303	1341	2703	
	8 Blank but applicable	19	3	58	
	Blank	135	12	70	
459	**Left nares-polyps**				
	1 Yes	4	0	4	
	4 No	7304	1342	2702	
	8 Blank but applicable	19	3	58	
	Blank	135	12	70	
460	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
	LIPS AND PHARYNX (POSITIONS 461-483)				
461	**Lips-cheilosis**				
	1 Yes	4	5	1	
	4 No	7320	1338	2760	
	8 Blank but applicable	3	2	3	
	Blank	135	12	70	
462	**Lips-cyanosis**				
	1 Yes	0	1	0	
	4 No	7322	1342	2758	
	8 Blank but applicable	5	2	6	
	Blank	135	12	70	
463	**Pharynx-enlarged tonsils**				
	1 Yes	501	22	88	
	4 No	6809	1321	2642	
	8 Blank but applicable	17	2	34	
	Blank	135	12	70	
464	**Blank**				
	EYES (POSITIONS 465-498)				
465	**Eyes-strabismus**				
	1 Yes	733	14	42	
	4 No	6587	1327	2718	
	8 Blank but applicable	7	4	4	
	Blank	135	12	70	
466	**Eyes-conjunctival injection**				
	1 Yes	84	9	9	
	4 No	7240	1332	2753	
	8 Blank but applicable	3	4	2	
	Blank	135	12	70	
467	**Eyes-pale conjunctiva**				
	1 Yes	14	0	4	
	4 No	7309	1341	2758	
	8 Blank but applicable	4	4	2	
	Blank	135	12	70	
468	**Eyes-xerophthalmia**				
	1 Yes	0	0	0	
	4 No	7323	1341	2762	
	8 Blank but applicable	4	4	2	
	Blank	135	12	70	
469	**Eyes-keratomalacia**				
	1 Yes	0	0	0	
	4 No	7323	1341	2762	
	8 Blank but applicable	4	4	2	
	Blank	135	12	70	
470	**Eyes-pterygium**				
	1 Yes	267	32	48	
	4 No	7056	1309	2714	
	8 Blank but applicable	4	4	2	
	Blank	135	12	70	
471	**Right eye-corneal lesion(s)**				
	1 Yes	23	5	1	
	4 No	7243	1337	2756	
	8 Blank but applicable	56	3	7	
	Blank	140	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
472	**Left eye-corneal lesion(s)**				
	1 Yes	23	3	4	
	4 No	7243	1338	2751	
	8 Blank but applicable	56	3	7	
	Blank	140	13	72	
473	**Eyes-pupils**				
	1 Right larger	18	4	12	
	2 Left larger	13	6	3	
	4 Equal	7281	1331	2738	
	8 Blank but applicable	5	3	9	
	Blank	145	13	72	
474	**Eyes-pupillary light reflex**				
	1 Abnormal	32	13	20	
	4 Normal	7293	1328	2734	
	8 Blank but applicable	2	4	10	
	Blank	135	12	70	
475	**Right eye-globe absent**				See Note 16
	1 Absent	5	0	0	
	Blank-present or exam not given	7457	1357	2834	
476	**Left eye-globe absent**				See Note 16
	1 Absent	5	1	2	
	Blank-present or exam not given	7457	1356	2832	
477	**Right eye-ocular fundus-red reflex**				
	1 Abnormal	15	3	6	
	4 Normal	7261	1314	2734	
	8 Blank but applicable	46	28	22	
	Blank	140	12	70	
478	**Left eye-ocular fundus-red reflex**				
	1 Abnormal	12	0	8	
	4 Normal	7266	1317	2732	
	8 Blank but applicable	44	27	22	
	Blank	140	13	72	
479	**Right eye-lens opacities**				
	1 Yes	58	16	18	
	4 No	7203	1301	2724	
	8 Blank but applicable	61	28	22	
	Blank	140	12	70	
480	**Left eye-lens opacities**				
	1 Yes	58	19	23	
	4 No	7207	1299	2717	
	8 Blank but applicable	57	26	22	
	Blank	140	13	72	
481	**Right eye-fundus visualization**				See Note 17
	1 Not visualized	254	66	219	
	Blank Visualized	7165	1277	2596	
	8 Blank but applicable	43	14	19	
482	**Left eye-fundus visualization**				See Note 17
	1 Not visualized	276	69	231	
	Blank Visualized	7144	1276	2584	
	8 Blank but applicable	42	12	19	

Position	Item description and code	Counts M	C	P	Source and notes
483	**Right eye-ocular fundus-narrow arterioles**				
	1 Yes	110	2	6	
	4 No	6892	1263	2512	
	8 Blank but applicable	66	14	27	
	Blank	394	78	289	
484	**Left eye-ocular fundus-narrow arterioles**				
	1 Yes	149	11	32	
	4 No	6834	1252	2471	
	8 Blank but applicable	63	12	28	
	Blank	416	82	303	
485	**Right eye-ocular fundus-tortuous arterioles**				
	1 Yes	42	2	5	
	4 No	6952	1263	2513	
	8 Blank but applicable	74	14	27	
	Blank	394	78	289	
486	**Left eye-ocular fundus-tortuous arterioles**				
	1 Yes	41	1	5	
	4 No	6934	1262	2499	
	8 Blank but applicable	71	12	27	
	Blank	416	82	303	
487	**Right eye-ocular fundus-AV compression**				
	1 Yes	25	0	11	
	4 No	6964	1265	2507	
	8 Blank but applicable	79	14	27	
	Blank	394	78	289	
488	**Left eye-ocular fundus-AV compression**				
	1 Yes	27	0	15	
	4 No	6943	1263	2489	
	8 Blank but applicable	76	12	27	
	Blank	416	82	303	
489	**Right eye-ocular fundus-hemorrhage**				
	1 Yes	4	0	0	
	4 No	6986	1265	2518	
	8 Blank but applicable	78	14	27	
	Blank	394	78	289	
490	**Left eye-ocular fundus-hemorrhage**				
	1 Yes	4	0	0	
	4 No	6967	1263	2504	
	8 Blank but applicable	75	12	27	
	Blank	416	82	303	
491	**Right eye-ocular fundus-exudate**				
	1 Yes	5	0	4	
	4 No	6983	1265	2515	
	8 Blank but applicable	80	14	26	
	Blank	394	78	289	

Position	Item description and code	Counts M	C	P	Source and notes
492	**Left eye-ocular fundus-exudate**				
	1 Yes	3	0	6	
	4 No	6966	1263	2499	
	8 Blank but applicable	77	12	26	
	Blank	416	82	303	
493	**Right eye-ocular fundus-venous engorgement**				
	1 Yes	1	0	0	
	4 No	6987	1264	2519	
	8 Blank but applicable	80	15	26	
	Blank	394	78	289	
494	**Left eye-ocular fundus-venous engorgement**				
	1 Yes	2	0	0	
	4 No	6967	1262	2505	
	8 Blank but applicable	77	13	26	
	Blank	416	82	303	
495	**Right eye-ocular fundus-papilledema**				
	1 Yes	0	0		
	4 No	6988	1265	2523	
	8 Blank but applicable	80	14	21	
	Blank	394	78	289	
496	**Left eye-ocular fundus-papilledema**				
	1 Yes	0	0	1	
	4 No	6969	1263	2509	
	8 Blank but applicable	77	12	21	
	Blank	416	82	303	
497	**Right eye-ocular fundus-disc abnormal**				
	1 Yes	3	1	10	
	4 No	6985	1264	2514	
	8 Blank but applicable	80	14	21	
	Blank	394	78	289	
498	**Left eye-ocular fundus-disc abnormal**				
	1 Yes	3	2	7	
	4 No	6966	1261	2503	
	8 Blank but applicable	77	12	21	
	Blank	416	82	303	
499	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
	NECK (POSITIONS 500-504)				
500	**Neck-enlarged lymph nodes**				
	1 Yes	449	22	198	
	4 No	6877	1322	2543	
	8 Blank but applicable	1	1	23	
	Blank	135	12	70	
501	**Neck-tender lymph nodes**				
	1 Yes	14	0	11	
	4 No	7310	1344	2729	
	8 Blank but applicable	3	1	24	
	Blank	135	12	70	
502	**Neck-thyroid evaluation-WHO classification**				See Appendix 1.9.2
	Grade 0	7300	1339	2714	
	Grade 1	24	5	12	
	Grade 2	4	0	3	
	Grade 3	0	0	1	
	8 Blank but applicable	2	1	34	
	Blank	135	12	70	
503	**Neck-tenderness**				
	1 Yes	1	0	2	
	4 No	7326	1344	2727	
	8 Blank but applicable	0	1	35	
	Blank	135	12	70	
504	**Neck-nodule**				
	1 Yes	3	2	4	
	4 No	7324	1342	2725	
	8 Blank but applicable	0	1	35	
	Blank	135	12	70	
505	**Blank**				

Position	Item description and code	Counts M	C	F	Source and notes
	PULSE (POSITIONS 506-509; AGES 6 YEARS AND OVER)				
506-508	**Pulse-rate (beats per minutes)**				
	040-176	6088	1244	2386	
	888 Blank but applicable	14	2	5	
	Blank	1360	111	443	
509	**Pulse-regularity**				
	1 Irregular	26	9	16	
	2 Regular	6047	1234	2365	
	8 Blank but applicable	29	3	10	
	Blank	1360	111	443	
	BLOOD PRESSURE (POSITIONS 510-518; AGES 6 YEARS AND OVER)				
510	**Blood pressure-cuff width**				
	1 Infant	24	5	7	
	2 Child	1676	170	506	
	3 Adult	3839	934	1594	
	4 Large arm	534	133	272	
	5 Thigh	8	2	6	
	8 Blank but applicable	21	2	9	
	Blank	1360	111	443	
511-513	**Blood pressure-systolic**				See Note 18
	070-240	6090	1243	2385	
	888 Blank but applicable	12	3	6	
	Blank	1360	111	443	
514-516	**Blood pressure-diastolic**				See Note 18
	000-138	6090	1243	2384	
	888 Blank but applicable	12	3	7	
	Blank	1360	111	443	
517	**Blank**				
	CHEST FINDINGS AND CVA TENDERNESS (POSITIONS 518-565)				
518	**Chest-beading of ribs**				
	1 Yes	1	0	1	
	4 No	7315	1343	2756	
	8 Blank but applicable	11	2	7	
	Blank	135	12	70	
519	**Chest-asymmetry**				
	1 Yes	32	4	9	
	4 No	7285	1339	2748	
	8 Blank but applicable	10	2	7	
	Blank	135	12	70	
520	**Chest-funnel breast**				
	1 Yes	27	0	7	
	4 No	7289	1343	2750	
	8 Blank but applicable	11	2	7	
	Blank	135	12	70	
521	**Chest-pigeon breast**				
	1 Yes	13	0	3	
	4 No	7303	1343	2754	
	8 Blank but applicable	11	2	7	
	Blank	135	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
522	**Chest-increased A.P. diameter**				
	1 Yes	48	0	14	
	4 No	7267	1343	2743	
	8 Blank but applicable	12	2	7	
	Blank	135	12	70	
523	**CVA tenderness**				
	1 Yes	97	14	50	
	4 No	7052	1308	2667	
	8 Blank but applicable	178	23	47	
	Blank	135	12	70	
524	**Chest-diminished breath sounds-area 1**				See Note 19
	1 Yes	12	4	6	
	8 Blank but applicable	5	2	7	
	Blank	7445	1351	2821	
525	**Chest-diminished breath sounds-area 2**				
	2 Yes	12	4	5	
	8 Blank but applicable	5	2	7	
	Blank	7445	1351	2822	
526	**Chest-diminished breath sounds-area 3**				
	3 Yes	13	4	6	
	8 Blank but applicable	5	2	7	
	Blank	7444	1351	2821	
527	**Chest-diminished breath sounds-area 4**				
	4 Yes	15	4	4	
	8 Blank but applicable	5	2	7	
	Blank	7442	1351	2823	
528	**Chest-diminished breath sounds-area 5**				
	5 Yes	15	4	7	
	8 Blank but applicable	5	2	7	
	Blank	7442	1351	2820	
529	**Chest-diminished breath sounds-area 6**				
	6 Yes	17	6	5	
	8 Blank but applicable	5	2	7	
	Blank	7440	1349	2822	
530	**Chest-diminished breath sounds in any area**				
	4 No diminished breath sounds	7302	1337	2746	
	8 Blank but applicable	5	2	7	
	Blank	155	18	81	
531	**Chest-absent breath sounds-area 1**				See Note 19
	1 Yes	0	0	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1355	2827	
532	**Chest-absent breath sounds-area 2**				
	2 Yes	0	1	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1354	2827	

Position	Item description and code	Counts M	C	P	Source and notes
533	**Chest-absent breath sounds-area 3**				
	3 Yes	0	0	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1355	2827	
534	**Chest-absent breath sounds-area 4**				
	4 Yes	0	1	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1354	2827	
535	**Chest-absent breath sounds-area 5**				
	5 Yes	0	0	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1355	2827	
536	**Chest-absent breath sounds-area 6**				
	6 Yes	0	0	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1355	2827	
537	**Breath sounds heard in all areas**				
	4 Yes	7322	1342	2757	
	8 Blank but applicable	5	2	7	
	Blank	135	13	70	
538	**Chest-bronchial breath sounds-area 1**				See Note 19
	1 Yes	7	0	4	
	8 Blank but applicable	5	2	7	
	Blank	7450	1355	2823	
539	**Chest-bronchial breath sounds-area 2**				
	2 Yes	7	0	5	
	8 Blank but applicable	5	2	7	
	Blank	7450	1355	2822	
540	**Chest-bronchial breath sounds-area 3**				
	3 Yes	13	0	7	
	8 Blank but applicable	5	2	7	
	Blank	7444	1355	2820	
541	**Chest-bronchial breath sounds-area 4**				
	4 Yes	13	0	7	
	8 Blank but applicable	5	2	7	
	Blank	7444	1355	2820	
542	**Chest-bronchial breath sounds-area 5**				
	5 Yes	11	0	4	
	8 Blank but applicable	5	2	7	
	Blank	7446	1355	2823	
543	**Chest-bronchial breath sounds-area 6**				
	6 Yes	11	0	5	
	8 Blank but applicable	5	2	7	
	Blank	7446	1355	2822	

Position	Item description and code	Counts M	C	P	Source and notes
544	**Chest-bronchial breath sounds in any area**				
	4 No bronchial breath sounds	7304	1343	2747	
	8 Blank but applicable	5	2	7	
	Blank	153	12	80	
545	**Chest-rales-area 1**				See Note 19
	1 Yes	0	0	0	
	8 Blank but applicable	5	2	7	
	Blank	7457	1355	2827	
546	**Chest-rales-area 2**				
	2 Yes	0	0	1	
	8 Blank but applicable	5	2	7	
	Blank	7457	1355	2826	
547	**Chest-rales-area 3**				
	3 Yes	3	2	1	
	8 Blank but applicable	5	2	7	
	Blank	7454	1353	2826	
548	**Chest-rales-area 4**				
	4 Yes	3	1	1	
	8 Blank but applicable	5	2	7	
	Blank	7454	1354	2826	
549	**Chest-rales-area 5**				
	5 Yes	3	1	1	
	8 Blank but applicable	5	2	7	
	Blank	7454	1354	2826	
550	**Chest-rales-area 6**				
	6 Yes	7	0	4	
	8 Blank but applicable	5	2	7	
	Blank	7450	1355	2823	
551	**Chest-rales in any area**				
	4 No rales	7313	1341	2752	
	8 Blank but applicable	5	2	7	
	Blank	144	14	75	
552	**Chest-rhonchi-area 1**				See Note 19
	1 Yes	14	2	3	
	8 Blank but applicable	4	2	7	
	Blank	7444	1353	2824	
553	**Chest-rhonchi-area 2**				
	2 Yes	15	2	5	
	8 Blank but applicable	4	2	7	
	Blank	7443	1353	2822	
554	**Chest-rhonchi-area 3**				
	3 Yes	22	5	5	
	8 Blank but applicable	4	2	7	
	Blank	7436	1350	2822	

Position	Item description and code	Counts M	C	P	Source and notes
555	**Chest-rhonchi-area 4**				
	4 Yes	24	3	6	
	8 Blank but applicable	4	2	7	
	Blank	7434	1352	2821	
556	**Chest-rhonchi-area 5**				
	5 Yes	20	1	4	
	8 Blank but applicable	4	2	7	
	Blank	7438	1354	2823	
557	**Chest-rhonchi-area 6**				
	6 Yes	18	0	5	
	8 Blank but applicable	4	2	7	
	Blank	7440	1355	2822	
558	**Chest-rhonchi in any area**				
	4 No rhonchi	7293	1338	2750	
	8 Blank but applicable	4	2	7	
	Blank	165	17	77	
559	**Chest-wheeze-area 1**				See Note 19
	1 Yes	23	9	46	
	8 Blank but applicable	7	2	7	
	Blank	7432	1346	2781	
560	**Chest-wheeze-area 2**				
	2 Yes	27	10	41	
	8 Blank but applicable	7	2	7	
	Blank	7428	1345	2786	
561	**Chest-wheeze-area 3**				
	3 Yes	22	8	39	
	8 Blank but applicable	7	2	7	
	Blank	7433	1347	2788	
562	**Chest-wheeze-area 4**				
	4 Yes	28	9	46	
	8 Blank but applicable	7	2	7	
	Blank	7427	1346	2781	
563	**Chest-wheeze-area 5**				
	5 Yes	18	6	35	
	8 Blank but applicable	7	2	7	
	Blank	7437	1349	2792	
564	**Chest-wheeze-area 6**				
	6 Yes	20	6	40	
	8 Blank but applicable	7	2	7	
	Blank	7435	1348	2787	
565	**Chest-wheezes in any area**				
	4 No wheezes	7274	1328	2683	
	8 Blank but applicable	7	2	7	
	Blank	181	27	144	
566-567	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
	BREAST MASS(ES) (POSITIONS 565-569; AGES 10 YEARS AND OVER)				
568	**Right breast mass(es)**				See Note 20
	1 Yes	18	3	30	
	4 No	5151	1115	2023	
	8 Blank but applicable	59	41	43	
	Blank	2234	198	738	
569	**Left breast mass(es)**				See Note 20
	1 Yes	15	3	37	
	4 No	5150	1116	2017	
	8 Blank but applicable	63	40	42	
	Blank	2234	198	738	
570	**Blank**				
	HEART (POSITIONS 571-597)				
571	**Heart-right carotid pulsations**				
	1 Absent	0	0	5	
	2 Diminished	24	2	25	
	4 Normal	7285	1336	2678	
	8 Blank but applicable	18	7	56	
	Blank	135	12	70	
572	**Heart-right carotid bruit**				
	1 Yes	55	1	27	
	4 No	7224	1335	2680	
	8 Blank but applicable	48	9	57	
	Blank	135	12	70	
573	**Heart-left carotid pulsations**				
	1 Absent	0	0	4	
	2 Diminished	34	6	24	
	4 Normal	7273	1332	2680	
	8 Blank but applicable	20	7	56	
	Blank	135	12	70	
574	**Heart-left carotid bruit**				
	1 Yes	53	0	21	
	4 No	7221	1336	2686	
	8 Blank but applicable	53	9	57	
	Blank	135	12	70	
575	**Heart-P.M.I. (ages 18 years and over)**				
	1 Felt	3139	717	781	
	2 Not felt	591	220	672	
	8 Blank but applicable	37	11	17	
	Blank	3695	409	1364	

Position	Item description and code	Counts M	C	P	Source and notes
576	**Heart-P.M.I. location-interspace**				
	4 4th interspace	1044	107	83	
	5 5th interspace	2062	574	650	
	6 6th interspace	24	36	46	
	7 7th interspace	7	0	2	
	8 Blank but applicable	39	11	17	
	Blank	4286	629	2036	
577	**Heart-P.M.I. location-midclavicular line**				
	1 At	3010	659	743	
	2 Inside	53	37	27	
	3 Outside	72	20	11	
	8 Blank but applicable	41	12	17	
	Blank	4286	629	2036	
578	**Heart-thrills**				
	1 Yes	0	0	1	
	4 No	7287	1334	2741	
	8 Blank but applicable	40	11	22	
	Blank	135	12	70	
579	**Heart-thrills-location**				
	1 Base	0	0	0	
	2 Apex	0	0	1	
	8 Blank but applicable	40	11	22	
	Blank	7422	1346	2811	
580	**Heart-first sound**				
	1 Accentuated	3	0	4	
	2 Diminished	14	0	9	
	4 Normal	7298	1342	2744	
	8 Blank but applicable	12	3	7	
	Blank	135	12	70	
581	**Heart-second sound-aortic**				
	1 Accentuated	11	0	2	
	2 Diminished	14	0	9	
	4 Normal	7290	1342	2746	
	8 Blank but applicable	12	3	7	
	Blank	135	12	70	
582	**Heart-second sound-pulmonic**				
	1 Accentuated	12	0	7	
	2 Diminished	12	0	9	
	4 Normal	7291	1342	2741	
	8 Blank but applicable	12	3	7	
	Blank	135	12	70	
583	**Heart-third sound**				
	1 Yes	12	0	0	
	2 Maybe	7	0	1	
	4 No	7294	1342	2754	
	8 Blank but applicable	14	3	9	
	Blank	135	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
584	**Heart-systolic click**				
	1 Yes	8	2	1	
	4 No	7304	1340	2754	
	8 Blank but applicable	15	3	9	
	Blank	135	12	70	
585	**Heart murmur(s)-present**				
	1 Yes	380	13	133	
	4 No	6930	1327	2623	
	8 Blank but applicable	17	5	8	
	Blank	135	12	70	
586	**Heart murmur-first systolic murmur-location**				
	1 Mitral	66	3	28	
	2 Aortic	215	9	62	
	3 Tricuspid	0	0	26	
	4 Pulmonic	93	1	15	
	8 Blank but applicable	21	5	8	
	Blank	7067	1339	2693	
587	**Heart murmur-second systolic murmur-location**				
	1 Mitral	4	0	0	
	2 Aortic	2	0	0	
	3 Tricuspid	0	0	2	
	4 Pulmonic	2	0	1	
	8 Blank but applicable	16	5	8	
	Blank	7436	1352	2823	
588	**Heart murmur-first diastolic murmur-location**				
	1 Mitral	2	0	1	
	2 Aortic	9	0	0	
	3 Tricuspid	0	0	0	
	4 Pulmonic	2	0	0	
	8 Blank but applicable	18	5	8	
	Blank	7431	1352	2825	
589	**Heart murmur-second diastolic murmur-location**				
	1 Mitral	1	0	0	
	2 Aortic	1	0	0	
	3 Tricuspid	0	0	0	
	4 Pulmonic	0	0	1	
	8 Blank but applicable	18	5	8	
	Blank	7442	1352	2825	
590	**Heart murmur-first systolic murmur-type**				
	1 Functional	294	8	76	
	2 Organic	46	5	18	
	3 Don't know	37	0	39	
	8 Blank but applicable	18	5	8	
	Blank	7067	1339	2693	

Position	Item description and code	Counts M	C	P	Source and notes
591	**Heart murmur-second systolic murmur-type**				
	1 Functional	1	0	1	
	2 Organic	7	0	1	
	3 Don't know	0	0	1	
	8 Blank but applicable	18	5	8	
	Blank	7436	1352	2823	
592	**Heart murmur-first diastolic murmur-type**				
	1 Functional	0	0	0	
	2 Organic	9	0	1	
	3 Don't know	2	0	0	
	8 Blank but applicable	20	5	8	
	Blank	7431	1352	2825	
593	**Heart murmur-second diastolic murmur-type**				
	1 Functional	0	0	0	
	2 Organic	1	0	0	
	3 Don't know	0	0	0	
	8 Blank but applicable	19	5	9	
	Blank	7442	1352	2825	
594	**Heart murmur-first systolic murmur-grade**				
	1 Grade 1	111	4	40	
	2 Grade 2	215	6	74	
	3 Grade 3	44	1	16	
	4 Grade 4	6	2	2	
	5 Grade 5	1	0	0	
	6 Grade 6	0	0	0	
	8 Blank but applicable	18	5	9	
	Blank	7067	1339	2693	
595	**Heart murmur-second systolic murmur-grade**				
	1 Grade 1	0	0	0	
	2 Grade 2	3	0	2	
	3 Grade 3	4	0	1	
	4 Grade 4	1	0	0	
	5 Grade 5	0	0	0	
	6 Grade 6	0	0	0	
	8 Blank but applicable	18	5	8	
	Blank	7436	1352	2823	
596	**Heart murmur-first diastolic murmur-grade**				
	1 Grade 1	4	0	0	
	2 Grade 2	4	0	0	
	3 Grade 3	4	0	0	
	4 Grade 4	1	0	1	
	5 Grade 5	0	0	0	
	6 Grade 6	0	0	0	
	8 Blank but applicable	18	5	8	
	Blank	7431	1352	2825	

Position	Item description and code	Counts M	C	P	Source and notes
597	**Heart murmur-second diastolic murmur-grade**				
	1 Grade 1	1	0	0	
	2 Grade 2	1	0	0	
	3 Grade 3	0	0	1	
	4 Grade 4	0	0	0	
	5 Grade 5	0	0	0	
	6 Grade 6	0	0	0	
	8 Blank but applicable	18	5	8	
	Blank	7442	1352	2825	
598	**Blank**				
	ABDOMEN (POSITIONS 599-842)				
599	**Abdomen-surgical scar(s)**				
	1 Yes	1201	356	499	
	4 No	6115	985	2254	
	8 Blank but applicable	11	4	11	
	Blank	135	12	70	
600	**Abdomen-scar(s)-area 1**				See Note 21
	1 Yes	219	15	44	
	0 Blank but applicable	13	4	11	
	Blank	7230	1338	2779	
601	**Abdomen-scar(s)-area 2**				
	2 Yes	99	49	43	
	0 Blank but applicable	13	4	11	
	Blank	7350	1304	2780	
602	**Abdomen-scar(s)-area 3**				
	3 Yes	12	1	5	
	0 Blank but applicable	13	4	11	
	Blank	7437	1352	2818	
603	**Abdomen-scar(s)-area 4**				
	4 Yes	67	32	64	
	0 Blank but applicable	13	4	11	
	Blank	7382	1321	2759	
604	**Abdomen-scar(s)-area 5**				
	5 Yes	245	109	148	
	0 Blank but applicable	13	4	11	
	Blank	7204	1244	2675	
605	**Abdomen-scar(s)-area 6**				
	6 Yes	19	5	6	
	0 Blank but applicable	13	4	11	
	Blank	7430	1348	2817	
606	**Abdomen-scar(s)-area 7**				
	7 Yes	391	213	135	
	0 Blank but applicable	13	4	11	
	Blank	7058	1140	2688	

Position	Item description and code	Counts M	C	P	Source and notes
607	**Abdomen-scar(s)-area 8**				
	8 Yes	596	175	309	
	0 Blank but applicable	13	4	11	
	Blank	6853	1178	2514	
608	**Abdomen-scar(s)-area 9**				
	9 Yes	50	41	47	
	0 Blank but applicable	13	4	11	
	Blank	7399	1312	2776	
609	**Abdomen-ascites**				
	1 Yes	2	0	0	
	4 No	7308	1341	2745	
	8 Blank but applicable	17	4	19	
	Blank	135	12	70	
610	**Abdomen bruit**				
	1 Yes	0	1	1	
	4 No	7309	1340	2731	
	8 Blank but applicable	16	1	32	
	Blank	135	12	70	
611	**Abdomen-bruit-area 1**				See Note 21
	1 Yes	0	0	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2802	
612	**Abdomen-bruit-area 2**				
	2 Yes	0	0	1	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2801	
613	**Abdomen-bruit-area 3**				
	3 Yes	0	0	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2802	
614	**Abdomen-bruit-area 4**				
	4 Yes	0	0	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2802	
615	**Abdomen-bruit-area 5**				
	5 Yes	0	1	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1352	2802	
616	**Abdomen-bruit-area 6**				
	6 Yes	0	0	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2802	
617	**Abdomen-bruit-area 7**				
	7 Yes	0	0	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2802	

Position	Item description and code	Counts M	C	P	Source and notes
618	**Abdomen-bruit-area 8**				
	8 Yes	0	1	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1352	2802	
619	**Abdomen-bruit-area 9**				
	9 Yes	0	0	0	
	0 Blank but applicable	18	4	32	
	Blank	7444	1353	2802	
620	**Abdomen-hepatomegaly**				
	1 Yes	13	4	4	
	4 No	7294	1337	2743	
	8 Blank but applicable	20	4	17	
	Blank	135	12	70	
621	**Abdomen-splenomegaly**				
	1 Yes	[illegible]	0	0	
	4 No	7306	1341	2747	
	8 Blank but applicable	20	4	17	
	Blank	135	12	70	
622	**Abdomen-uterine enlargement**				See Note 22
	1 Yes	72	5	19	
	4 No	3774	708	1531	
	8 Blank but applicable	21	1	16	
	Blank	3595	643	1268	
623	**Abdomen-tenderness on palpation**				
	1 Yes	108	20	130	
	4 No	7202	1321	2612	
	8 Blank but applicable	17	4	22	
	Blank	135	12	70	
624	**Abdomen-tenderness on palpation-area 1**				See Note 21
	1 Yes	19	4	11	
	0 Blank but applicable	17	4	22	
	Blank	7426	1349	2801	
625	**Abdomen-tenderness on palpation-area 2**				
	2 Yes	15	1	17	
	0 Blank but applicable	17	4	22	
	Blank	7430	1352	2795	
626	**Abdomen-tenderness on palpation-area 3**				
	3 Yes	18	2	13	
	0 Blank but applicable	17	4	22	
	Blank	7427	1351	2799	
627	**Abdomen-tenderness on palpation-area 4**				
	4 Yes	12	2	19	
	0 Blank but applicable	17	4	22	
	Blank	7433	1351	2793	

Position	Item description and code	Counts M	C	P	Source and notes
628	**Abdomen-tenderness on palpation-area 5**				
	5 Yes	23	11	34	
	0 Blank but applicable	17	4	22	
	Blank	7422	1342	2778	
629	**Abdomen-tenderness on palpation-area 6**				
	6 Yes	21	3	32	
	0 Blank but applicable	17	4	22	
	Blank	7424	1350	2780	
630	**Abdomen-tenderness on palpation-area 7**				
	7 Yes	33	3	23	
	0 Blank but applicable	17	4	22	
	Blank	7412	1350	2789	
631	**Abdomen-tenderness on palpation-area 8**				
	8 Yes	46	4	29	
	0 Blank but applicable	17	4	22	
	Blank	7399	1349	2783	
632	**Abdomen-tenderness on palpation-area 9**				
	9 Yes	44	2	35	
	0 Blank but applicable	17	4	22	
	Blank	7401	1351	2777	
633	**Abdomen-mass(es)**				
	1 Yes	51	1	3	
	4 No	7256	1341	2733	
	6 Blank but applicable	20	3	28	
	Blank	135	12	70	
634	**Abdomen-mass(es)-area 1**				See Note 21
	1 Yes	1	0	0	
	0 Blank but applicable	20	3	28	
	Blank	7441	1354	2806	
635	**Abdomen-mass(es)-area 2**				
	2 Yes	2	0	0	
	0 Blank but applicable	20	3	28	
	Blank	7440	1354	2806	
636	**Abdomen-mass(es)-area 3**				
	3 Yes	1	0	0	
	0 Blank but applicable	20	3	28	
	Blank	7441	1354	2806	
637	**Abdomen-mass(es)-area 4**				
	4 Yes	2	0	0	
	0 Blank but applicable	20	3	28	
	Blank	7440	1354	2806	
638	**Abdomen-mass(es)-area 5**				
	5 Yes	18	1	1	
	0 Blank but applicable	20	3	28	
	Blank	7424	1353	2805	

Position	Item description and code	Counts M	C	P	Source and notes
639	**Abdomen-mass(es)-area 6**				
	6 Yes	2	0	0	
	0 Blank but applicable	20	3	28	
	Blank	7440	1354	2806	
640	**Abdomen-mass(es)-area 7**				
	7 Yes	6	0	0	
	0 Blank but applicable	20	3	28	
	Blank	7436	1354	2806	
641	**Abdomen-mass(es)-area 8**				
	8 Yes	34	0	1	
	0 Blank but applicable	20	3	28	
	Blank	7408	1354	2805	
642	**Abdomen-mass(es)-area 9**				
	9 Yes	3	0	2	
	0 Blank but applicable	20	3	28	
	Blank	7439	1354	2804	
643	**Blank**				
	GALLBLADDER QUESTIONS				
	ATTENTION: ONLY THE FASTING GROUP (AGES 20-74 YEARS) WERE ASKED THE QUESTIONS IN POSITIONS 644-647.				
644	**During the past year has this examinee had any attacks of nausea and/or vomiting lasting more than 2 hours?**				
	1 Yes	36	29	52	
	2 No	1349	414	582	
	8 Blank but applicable	349	3	22	
	9 Do not know	0	0	5	
	Blank	5728	911	2173	
645	**During the past 5 years has this examinee had pain in the gallbladder area which lasted a half hour or more?**				
	1 Yes	77	51	92	
	2 No	1310	392	541	
	8 Blank but applicable	347	2	22	
	9 Do not know	0	1	6	
	Blank	5728	911	2173	
646	**Does this examinee usually feel sick to his/her stomach either before or after getting this pain?**				
	1 Yes	34	11	45	
	2 No	35	30	44	
	8 Blank but applicable	355	10	25	
	9 Do not know	0	2	0	
	Blank	7038	1304	2720	

Position	Item description and code	Counts M	C	P	Source and notes
647	**What is your opinion of the likelihood of this examinee having gallstones?**				See Notes 23
	1 Definitely, has gallstones	2	1	0	
	2 Probably has gallstones	11	12	12	
	3 Probably does not have gallstones	196	227	347	
	4 Definitely does not have gallstones	710	193	252	
	5 Unable to form opinion	6	3	19	
	8 Blank but applicable	76	10	31	
	Blank	6461	911	2173	
	TANNER STAGING (POSITIONS 648-650; AGES 10-17 YEARS)				
648	**Tanner staging-hair**				
	1 Stage 1	355	29	69	
	2 Stage 2	205	32	83	
	3 Stage 3	243	16	66	
	4 Stage 4	229	29	108	
	5 Stage 5	395	102	275	
	6 Blank but applicable	34	1	25	
	Blank	6001	1146	2208	
649	**Tanner staging-genitalia-males only**				
	1 Stage 1	218	21	42	
	2 Stage 2	113	20	43	
	3 Stage 3	105	12	39	
	4 Stage 4	129	13	49	
	5 Stage 5	149	50	128	
	8 Blank but applicable	15	0	12	
	Blank	6733	1241	2521	
650	**Tanner staging breasts-females only**				
	1 Stage 1	88	9	19	
	2 Stage 2	107	11	34	
	3 Stage 3	149	9	37	
	4 Stage 4	104	14	59	
	5 Stage 5	261	50	151	
	8 Blank but applicable	23	2	13	
	Blank	6730	1262	2521	
651	**Blank**				
	EXTREMITIES (POSITIONS 652-666)				
652	**Extremities-legs-abduction of hips (Ortolani's maneuver)-ages 6 months-2 years**				
	1 Abnormal	3	0	0	
	4 Normal	541	47	131	
	8 Blank but applicable	21	3	30	
	Blank	6897	1307	2673	

Position	Item description and code	Counts M	C	P	Source and notes
653	**Extremities-right leg-femoral pulsations**				
	1 Absent	5	1	30	
	2 Diminished	58	11	36	
	4 Normal	7251	1328	2624	
	8 Blank but applicable	13	5	74	
	Blank	135	12	70	
654	**Extremities-right leg-femoral bruit**				
	1 Yes	8	0	2	
	4 No	7278	1336	2685	
	8 Blank but applicable	41	9	77	
	Blank	135	12	70	
655	**Extremities-left leg-femoral pulsations**				
	1 Absent	6	0	29	
	2 Diminished	56	11	39	
	4 Normal	7250	1329	2622	
	8 Blank but applicable	13	5	74	
	Blank	135	12	70	
656	**Extremities-left leg-femoral bruit**				
	1 Yes	9	0	2	
	4 No	7276	1336	2684	
	8 Blank but applicable	42	9	76	
	Blank	135	12	70	
657	**Extremities-right leg-dorsalis pedis pulsations**				See Note 24
	1 Absent	179	59	87	
	2 Diminished	146	18	55	
	4 Normal	6971	1263	2579	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	24	5	43	
	Blank	135	12	70	
658	**Extremities-left leg-dorsalis pedis pulsation**				See Note 24
	1 Absent	195	56	93	
	2 Diminished	137	16	50	
	4 Normal	6956	1267	2574	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	28	6	45	
	Blank	135	12	70	
659	**Extremities-right leg-ulceration**				
	1 Yes	8	1	6	
	4 No	7283	1335	2718	
	8 Blank but applicable	36	9	40	
	Blank	135	12	70	
660	**Extremities-left leg-ulceration**				
	1 Yes	6	0	2	
	4 No	7285	1337	2721	
	8 Blank but applicable	36	8	41	
	Blank	135	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
661	**Extremities-right leg-edema**				
	1 Severe	0	0	0	
	2 Moderate	5	5	6	
	3 Mild	37	20	30	
	4 None	7268	1377	2701	
	6 Blank but applicable	17	3	27	
	Blank	135	12	70	
662	**Extremities-left leg-edema**				
	1 Severe	1	0	1	
	2 Moderate	8	5	8	
	3 Mild	42	21	32	
	4 None	7253	1316	2694	
	6 Blank but applicable	23	3	29	
	Blank	135	12	70	
	ATTENTION: THE STRAIGHT LEG-RAISING TEST (POSITIONS 663-666) WAS PERFORMED ON SAMPLE PERSONS AGES 18 YEARS AND OVER.				
663	**Extremities-right leg-straight leg raising test**				
	1 Abnormal	47	11	53	
	4 Normal	3694	934	1405	
	6 Blank but applicable	26	3	12	
	Blank	3695	409	1364	
664	**Extremities-left leg-straight leg raising test**				
	1 Abnormal	41	12	53	
	4 Normal	3698	934	1403	
	6 Blank but applicable	28	2	14	
	Blank	3695	409	1364	
665	**Extremities-right leg-straight leg raising test-pain with ankle dorsiflexion**				See Note 24
	1 Yes	21	5	7	
	4 No	3671	929	1398	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	21	3	12	
	Blank	3742	420	1417	
666	**Extremities-right leg-straight leg raising test-pain with ankle dorsiflexion**				See Note 24
	1 Yes	20	6	8	
	4 No	3672	928	1395	
	7 Extremity missing or immobilized	10	0	2	
	8 Blank but applicable	24	2	12	
	Blank	3736	421	1417	
667-668	**Blank**				

Position	Item description and code	Counts M	C	F	Source and notes
	JOINTS (POSTIONS 669-741; AGES 10 YEARS AND OVER)				
669	**Joints-right hip-tender**				
	1 Yes	14	3	13	
	8 Blank but applicable	9	1	9	
	Blank	7439	1353	2812	
670	**Joints-left hip-tender**				
	1 Yes	16	3	20	
	8 Blank but applicable	9	1	9	
	Blank	7437	1353	2805	
671	**Joints-right hip-swelling**				
	1 Yes	0	0	0	
	8 Blank but applicable	9	1	9	
	Blank	7453	1356	2825	
672	**Joints-left hip-swelling**				
	1 Yes	1	0	1	
	8 Blank but applicable	9	1	9	
	Blank	7452	1356	2824	
673	**Joints-right hip-deformity**				
	1 Yes	0	0	0	
	8 Blank but applicable	9	1	9	
	Blank	7453	1356	2825	
674	**Joints-left hip-deformity**				
	1 Yes	0	2	0	
	8 Blank but applicable	9	1	9	
	Blank	7453	1354	2825	
675	**Joints-right hip-limitation of motion**				
	1 Yes	62	48	56	
	8 Blank but applicable	9	1	9	
	Blank	7391	1306	2769	
676	**Joints-left hip-limitation of motion**				
	1 Yes	65	40	57	
	8 Blank but applicable	9	1	9	
	Blank	7388	1316	2768	
677	**Joints-both hips normal**				See Note 25
	1 Yes	5136	1105	2007	
	8 Blank but applicable	9	1	9	
	Blank	2317	251	818	
678	**Joints-right knee-tender**				See Note 24
	1 Yes	20	4	11	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	8	1	9	
	Blank	7429	1352	2814	
679	**Joints-left knee-tender**				See Note 24
	1 Yes	28	4	14	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	8	1	9	
	Blank	7421	1352	2811	

Position	Item description and code	Counts M	C	P	Source and notes
680	**Joints-right knee-swelling**				See Note 24
	1 Yes	7	1	2	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7442	1355	2823	
681	**Joints-left knee-swelling**				See Note 24
	1 Yes	10	4	2	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	8	1	9	
	Blank	7439	1352	2823	
682	**Joints-right knee-deformity**				See Note 24
	1 Yes	9	1	2	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	8	1	9	
	Blank	7440	1355	2823	
683	**Joints-left knee-deformity**				See Note 24
	1 Yes	8	1	2	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7441	1355	2823	
684	**Joints-right knee-limitation of motion**				See Note 24
	1 Yes	21	10	31	
	7 Extremity missing	5	0	0	
	8 Blank but applicable	8	1	9	
	Blank	7428	1346	2794	
685	**Joints-left knee-limitation of motion**				See Note 24
	1 Yes	31	13	36	
	7 Extremity missing or immobilized	5	0	0	
	8 Blank but applicable	8	1	9	
	Blank	7418	1343	2789	
686	**Joints-both knees normal**				See Notes 24,25
	1 Yes	5160	1136	2038	
	7 Both extremities missing or immobilized	1	0	0	
	8 Blank but applicable	8	1	9	
	Blank	2293	220	767	
687	**Joints-right ankle-tender**				See Note 24
	1 Yes	8	2	6	
	7 Extremity missing or immobilized	7	0	0	
	8 But applicable	6	1	9	
	Blank	7441	1354	2819	
688	**Joints-left ankle-tender**				See Note 24
	1 Yes	11	2	3	
	7 Extremity missing or immobilized	11	0	2	
	8 But applicable	6	1	9	
	Blank	7434	1354	2820	

Position	Item description and code	Counts N	C	P	Source and notes
689	**Joints-right ankle-swelling**				See Note 24
	1 Yes	9	0	3	
	7 Extremity missing or immobilized	7	0	0	
	8 But applicable	6	1	9	
	Blank	7440	1356	2822	
690	**Joints-left ankle-swelling**				See Note 24
	1 Yes	12	1	1	
	7 Extremity missing or immobilized	11	0	2	
	8 But applicable	6	1	9	
	Blank	7433	1355	2822	
691	**Joints-right ankle-deformity**				See Note 24
	1 Yes	12	1	0	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7437	1355	2825	
692	**Joints-left ankle-deformity**				See Note 24
	1 Yes	12	0	0	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	6	1	9	
	Blank	7433	1356	2823	
693	**Joints-right ankle-limitation of motion**				See Note 24
	1 Yes	12	9	21	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7437	1347	2804	
694	**Joints-left ankle-limitation of motion**				See Note 24
	1 Yes	20	8	21	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	6	1	9	
	Blank	7425	1348	2802	
695	**Joints-both ankles normal**				See Notes 24,25
	1 Yes	5182	1147	2058	
	7 Both extremities missing or immobilized	4	0	0	
	8 Blank but applicable	6	1	9	
	Blank	2270	209	767	
696	**Joints-right foot-tender**				See Note 24
	1 Yes	6	0	4	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7443	1356	2821	
697	**Joints-left foot-tender**				See Note 24
	1 Yes	6	1	3	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	6	1	9	
	Blank	7439	1355	2820	

Position	Item description and code	Counts M	Counts C	Counts F	Source and notes
698	**Joints-right foot-swelling**				See Note 24
	1 Yes	2	0	1	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7447	1356	2824	
699	**Joints-left foot-swelling**				See Note 24
	1 Yes	5	1	0	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	6	1	9	
	Blank	7440	1355	2823	
700	**Joints-right foot-deformity**				See Note 24
	1 Yes	8	1	1	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7441	1355	2824	
701	**Joints-left foot-deformity**				See Note 24
	1 Yes	10	1	1	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	6	1	9	
	Blank	7435	1355	2822	
702	**Joints-right foot-limitation of motion**				See Note 24
	1 Yes	8	9	20	
	7 Extremity missing or immobilized	7	0	0	
	8 Blank but applicable	6	1	9	
	Blank	7441	1347	2805	
703	**Joints-left foot-limitation of motion**				See Note 24
	1 Yes	13	8	21	
	7 Extremity missing or immobilized	11	0	2	
	8 Blank but applicable	6	1	9	
	Blank	7432	1348	2802	
704	**Joints-both feet normal**				See Notes 24,25
	1 Yes	5197	1145	2059	
	7 Both extremities missing or immobilized	4	0	0	
	8 Blank but applicable	6	1	9	
	Blank	2255	211	766	
705	**Joints-right shoulder-tender**				See Note 24
	1 Yes	34	5	7	
	7 Extremity missing or immobilized	0	0	1	
	8 Blank but applicable	5	1	8	
	Blank	7423	1351	2818	
706	**Joints-left shoulder-tender**				
	1 Yes	22	3	5	
	8 Blank but applicable	5	1	8	
	Blank	7435	1353	2821	

Position	Item description and code	Counts M	C	P	Source and notes
707	**Joints-right shoulder-swelling**				See Note 24
	1 Yes	1	1	1	
	7 Extremity missing or immobilized	0	0	1	
	8 Blank but applicable	5	1	8	
	Blank	7456	1355	2824	
708	**Joints-left shoulder-swelling**				
	1 Yes	1	0	0	
	8 Blank but applicable	5	1	8	
	Blank	7456	1356	2826	
709	**Joints-right shoulder-deformity**				See Note 24
	1 Yes	3	0	1	
	7 Extremity missing or immobilized	0	0	1	
	8 Blank but applicable	5	1	8	
	Blank	7454	1356	2824	
710	**Joints-left shoulder-deformity**				
	1 Yes	2	0	0	
	8 Blank but applicable	5	1	8	
	Blank	7455	1355	2826	
711	**Joints-right shoulder-limitation of motion**				See Note 24
	1 Yes	33	19	34	
	7 Extremity missing or immobilized	0	0	1	
	8 Blank but applicable	5	1	8	
	Blank	7424	1337	2791	
712	**Joints-left shoulder-limitation of motion**				
	1 Yes	23	17	36	
	8 Blank but applicable	5	1	8	
	Blank	7434	1339	2790	
713	**Joints-both shoulders normal**				See Note 25
	1 Yes	5161	1133	2037	
	8 Blank but applicable	5	1	8	
	Blank	2296	223	789	
714	**Joint-right elbow-tender**				See Note 24
	1 Yes	5	2	3	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	5	1	7	
	Blank	7450	1354	2823	
715	**Joint-left elbow-tender**				See Note 24
	1 Yes	4	3	2	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	5	1	7	
	Blank	7452	1353	2825	
716	**Joint-right elbow-swelling**				See Note 24
	1 Yes	4	0	1	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	5	1	7	
	Blank	7451	1356	2825	

Position	Item description and code	Counts M	C	P	Source and notes
717	**Joint-left elbow-swelling**				See Note 24
	1 Yes	3	C	2	
	7 Extremity missing or immobilized	1	C	O	
	8 Blank but applicable	5	1	7	
	Blank	7453	1356	2825	
718	**Joint-right elbow-deformity**				See Note 24
	1 Yes	7	C	4	
	7 Extremity missing or immobilized	2	O	1	
	8 Blank but applicable	5	1	7	
	Blank	7448	1356	2822	
719	**Joint-left elbow-deformity**				See Note 24
	1 Yes	10	O	5	
	7 Extremity missing or immobilized	1	O	C	
	8 Blank but applicable	5	1	7	
	Blank	7446	1356	2822	
720	**Joints-right elbow-limitation of motion**				See Note 24
	1 Yes	12	10	27	
	7 Extremity missing or immobilized	2	C	1	
	8 Blank but applicable	5	1	7	
	Blank	7443	1346	2799	
721	**Joints-left elbow-limitation of motion**				See Note 24
	1 Yes	12	8	24	
	7 Extremity missing or immobilized	1	O	O	
	8 Blank but applicable	5	1	7	
	Blank	7444	1348	2803	
722	**Joints-both elbows normal**				See Notes 25
	1 Yes	5194	1144	2052	
	8 Blank but applicable	5	1	7	
	Blank	2263	212	775	
723	**Joints-right wrist-tender**				See Note 24
	1 Yes	7	1	3	
	7 Extremity missing or immobilized	2	O	1	
	8 Blank but applicable	5	1	8	
	Blank	7448	1355	2822	
724	**Joints-left wrist-tender**				See Note 24
	1 Yes	5	1	3	
	7 Extremity missing or immobilized	1	C	C	
	8 Blank but applicable	5	1	8	
	Blank	7451	1355	2823	
725	**Joints-right wrist-swelling**				See Note 24
	1 Yes	3	O	2	
	7 Extremity missing or immobilized	2	O	1	
	8 Blank but applicable	5	1	8	
	Blank	7452	1356	2823	

Position	Item description and code	Counts M	C	P	Source and notes
726	**Joints-left wrist-swelling**				See Note 24
	1 Yes	4	0	2	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	5	1	6	
	Blank	7452	1356	2824	
727	**Joints-right wrist-deformity**				See Note 24
	1 Yes	11	0	1	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	5	1	8	
	Blank	7444	1356	2824	
728	**Joints-left wrist-deformity**				See Note 24
	1 Yes	13	1	1	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	5	1	6	
	Blank	7443	1355	2825	
729	**Joints-right wrist-limitation of motion**				See Note 24
	1 Yes	17	2	14	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	5	1	8	
	Blank	7444	1354	2811	
730	**Joints-left wrist-limitation of motion**				See Note 24
	1 Yes	14	2	13	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	5	1	8	
	Blank	7442	1354	2813	
731	**Joints-both wrists normal**				See Notes 24,25
	1 Yes	5196	1154	2067	
	7 Both extremities missing or immobilized	0	0	6	
	8 Blank but applicable	5	1	0	
	Blank	2261	202	759	
732	**Joints-right hand-tender**				See Note 24
	1 Yes	8	2	4	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	6	1	7	
	Blank	7446	1354	2822	
733	**Joints-left hand-tender**				See Note 24
	1 Yes	9	3	4	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	6	1	7	
	Blank	7446	1353	2823	
734	**Joints-right hand-swelling**				See Note 24
	1 Yes	6	6	2	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	6	1	7	
	Blank	7448	1350	2824	

Position	Item description and code	Counts M	C	P	Source and notes
735	**Joints-left hand-swelling**				See Note 24
	1 Yes	6	7	2	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	6	1	7	
	Blank	7447	1349	2825	
736	**Joints-right hand-deformity**				See Note 24
	1 Yes	25	5	14	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	6	1	7	
	Blank	7429	1351	2812	
737	**Joints-left hand-deformity**				See Note 24
	1 Yes	27	6	14	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	6	1	7	
	Blank	7426	1350	2813	
738	**Joints-right hand-limitation of motion**				See Note 24
	1 Yes	13	2	11	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	6	1	7	
	Blank	7441	1354	2815	
739	**Joints-left hand-limitation of motion**				See Note 24
	1 Yes	18	2	12	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	6	1	7	
	Blank	7437	1354	2815	
740	**Joints-both hands normal**				See Note 25
	1 Yes	5175	1143	2058	
	8 Blank but applicable	6	1	7	
	Blank	2281	213	769	
741	**Joints-epiphysial enlargement (ages 6 months-17 years)**				
	1 Yes	467	0	1	
	4 No	3031	350	1219	
	8 Blank but applicable	62	47	74	
	Blank	3902	960	1540	
742	**Blank**				

Position	Item description and code	Counts M	C	F	Source and notes
	NEUROLOGICAL EVALUATION (POSITIONS 743-756)				
	ATTENTION: THE COORDINATION AND SENSORY EXAMS (POSITIONS 743-748) WERE PERFORMED ON SAMPLE PERSONS AGES 5 YEARS AND OVER.				
743	**Neurologic-coordination-pronation/supination of right hand**				See Note 24
	1 Abnormal	12	4	6	
	4 Normal	6295	1252	2436	
	7 Extremity missing or immobilized	2	0	1	
	8 Blank but applicable	14	1	6	
	Blank	1139	100	385	
744	**Neurologic-coordination-pronation/supination of left hand**				See Note 24
	1 Abnormal	12	2	6	
	4 Normal	6295	1254	2434	
	7 Extremity missing or immobilized	1	0	0	
	8 Blank but applicable	15	4	4	
	Blank	1139	100	385	
745	**Neurologic-vibratory sensation-right arm**				
	1 Abnormal	15	3	3	
	4 Normal	6286	1254	2436	
	8 Blank but applicable	22	0	8	
	Blank	1139	100	385	
746	**Neurologic-vibratory sensation-left arm**				
	1 Abnormal	9	2	3	
	4 Normal	6292	1255	2438	
	8 Blank but applicable	22	0	8	
	Blank	1139	100	385	
747	**Neurologic-vibratory sensation-right leg**				
	1 Abnormal	26	5	10	
	4 Normal	6275	1252	2431	
	8 Blank but applicable	22	0	8	
	Blank	1139	100	385	
748	**Neurologic-vibratory sensation-left leg**				
	1 Abnormal	26	12	12	
	4 Normal	6273	1245	2427	
	8 Blank but applicable	24	0	10	
	Blank	1139	100	385	
749	**Neurologic-muscle weakness**				
	1 Yes	39	9	22	
	4 No	7269	1320	2729	
	8 Blank but applicable	19	16	13	
	Blank	135	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
750	**Neurologic-muscles-right arm paralysis**				
	1 Yes	6	0	0	
	4 No	7307	1329	2751	
	8 Blank but applicable	14	16	13	
	Blank	135	12	70	
751	**Neurologic-muscles-left arm paralysis**				
	1 Yes	6	0	0	
	4 No	7307	1329	2751	
	8 Blank but applicable	14	16	13	
	Blank	135	12	70	
752	**Neurologic-muscles-right leg paralysis**				
	1 Yes	7	1	3	
	4 No	7297	1328	2749	
	8 Blank but applicable	23	16	12	
	Blank	135	12	70	
753	**Neurologic-muscles-left leg paralysis**				
	1 Yes	10	1	3	
	4 No	7293	1328	2747	
	8 Blank but applicable	24	16	14	
	Blank	135	12	70	
754	**Neurologic-speech-stuttering (ages 5 years and over)**				
	1 Yes	11	0	2	
	4 No	6290	1257	2440	
	8 Blank but applicable	22	0	7	
	Blank	1139	100	385	
755	**Blank**	7462	1357	2834	
756	**Neurologic-knee jerk**				See Note 24
	1 Absent	192	27	88	
	4 Present	7091	1298	2656	
	7 Both extremities missing or immobilized	1	0	0	
	8 Blank but applicable	43	20	20	
	Blank	135	12	70	
757-758	**Blank**				

Position	Item description and code	Counts M	Counts C	Counts P	Source and notes
	SKIN EVALUATION (POSITIONS 759-778)				
759	**Skin-follicular hyperkeratosis-arms**				
	1 Yes	3	4	1	
	4 No	7319	1339	2754	
	8 Blank but applicable	5	2	9	
	Blank	135	12	70	
760	**Skin-follicular hyperkeratosis-back**				
	1 Yes	3	6	1	
	4 No	7319	1337	2754	
	8 Blank but applicable	5	2	9	
	Blank	135	12	70	
761	**Skin-hyperpigmentation, hands and face**				
	1 Yes	14	8	5	
	4 No	7306	1335	2750	
	8 Blank but applicable	5	2	9	
	Blank	135	12	70	
762	**Skin-dry or scaling**				
	1 Yes	75	16	7	
	4 No	7248	1327	2748	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
763	**Skin-perifolliculitis**				
	1 Yes	8	1	1	
	4 No	7315	1342	2754	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
764	**Skin-petechiae**				
	1 Yes	9	3	9	
	4 No	7314	1340	2745	
	8 Blank but applicable	4	2	10	
	Blank	135	12	70	
765	**Blank**				
766	**Skin-mosaic**				
	1 Yes	3	6	5	
	4 No	7320	1337	2750	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
767	**Skin-pellagrous dermatitis**				
	1 Yes	0	0	1	
	4 No	7323	1343	2754	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
768	**Skin-ecchymoses**				
	1 Yes	6	7	11	
	4 No	7317	1336	2744	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
769	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
770	**Skin-spider angioma**				
	1 Yes	12	5	7	
	4 No	7311	1338	2748	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
771	**Skin-eczema**				
	1 Yes	60	8	24	
	4 No	7263	1335	2731	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
772	**Skin-inflammation**				
	1 Yes	14	1	12	
	4 No	7309	1342	2743	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
773	**Skin-impetigo**				
	1 Yes	3	1	2	
	4 No	7320	1342	2753	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
774	**Skin-scars**				
	1 Yes	28	12	32	
	4 No	7295	1331	2723	
	8 Blank but applicable	4	2	9	
	Blank	135	12	70	
775	**Skin-urticaria**				
	1 Yes	7	2	1	
	4 No	7315	1341	2753	
	8 Blank but applicable	5	2	10	
	Blank	135	12	70	
776	**Skin-infestation**				
	1 Yes	7	1	16	
	4 No	7312	1342	2739	
	8 Blank but applicable	6	2	9	
	Blank	135	12	70	
777	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
	PULSE (POSITIONS 778-781; ALL AGES)				
778-780	**Pulse-rate (beats per minute)**				
	040-192	7262	1329	2729	
	888 Blank but applicable	65	16	35	
	Blank	135	12	70	
781	**Pulse-regularity**				
	1 Irregular	29	9	16	
	2 Regular	7171	1280	2672	
	8 Blank but applicable	127	56	76	
	Blank	135	12	70	
	BLOOD PRESSURE READING (POSITIONS 782-788; AGES 6 YEARS AND OVER)				
782	**Blood pressure-cuff width**				
	1 Infant	25	5	5	
	2 Child	1651	167	510	
	3 Adult	3859	936	1587	
	4 Large arm	539	134	271	
	5 Thigh	7	2	6	
	8 Blank but applicable	21	2	12	
	Blank	1360	111	443	
783-785	**Blood pressure-systolic**				See Note 18
	070-246	6084	1240	2382	
	888 Blank but applicable	18	6	9	
	Blank	1360	111	443	
786-788	**Blood pressure-diastolic**				See Note 18
	000-138	6084	1240	2380	
	888 Blank but applicable	18	6	11	
	Blank	1360	111	443	
789	**Blank**				
	BACK (POSITIONS 790-805; AGES 5 YEARS AND OVER)				
790	**Back-scoliosis**				
	1 Yes	301	85	170	
	4 No	6012	1172	2269	
	8 Blank but applicable	10	0	10	
	Blank	1139	100	385	
791	**Back-kyphosis**				
	1 Yes	201	22	21	
	4 No	6113	1234	2417	
	8 Blank but applicable	9	1	11	
	Blank	1139	100	385	
792	**Back-lordosis**				
	1 Yes	166	3	12	
	4 No	6142	1252	2425	
	8 Blank but applicable	15	2	12	
	Blank	1139	100	385	
793	**Back-right sciatic notch tenderness**				
	1 Yes	32	8	59	
	4 No	6274	1248	2377	
	8 Blank but applicable	17	1	13	
	Blank	1139	100	385	

Position	Item description and code	Counts M	C	P	Source and notes
794	**Back-left sciatic notch tenderness**				
	1 Yes	28	6	55	
	4 No	6278	1248	2381	
	8 Blank but applicable	17	1	13	
	Blank	1139	100	385	
795	**Back-right sacroiliac tenderness**				
	1 Yes	72	10	75	
	4 No	6235	1246	2364	
	8 Blank but applicable	16	1	10	
	Blank	1139	100	385	
796	**Back-left sacroiliac tenderness**				
	1 Yes	64	10	68	
	4 No	6243	1246	2371	
	8 Blank but applicable	16	1	10	
	Blank	1139	100	385	
797	**Blank**				
798	**Back-lumbar spine limitation of motion-flexion**				
	1 Yes	92	31	86	
	4 No	6206	1224	2341	
	8 Blank but applicable	25	2	20	
	Blank	1139	100	385	
799	**Back-lumbar spine limitation of motion-extension**				
	1 Yes	94	39	111	
	4 No	6204	1215	2319	
	8 Blank but applicable	25	3	19	
	Blank	1139	100	385	
800	**Back-lumbar spine limitation of motion-right lateral bending**				
	1 Yes	79	26	79	
	4 No	6217	1229	2353	
	8 Blank but applicable	27	2	17	
	Blank	1139	100	385	
801	**Back-lumbar spine limitation of motion-left lateral bending**				
	1 Yes	74	26	80	
	4 No	6222	1229	2352	
	8 Blank but applicable	27	2	17	
	Blank	1139	100	385	
802	**Back-lumbar spine limitation of motion-right rotation**				
	1 Yes	130	29	69	
	4 No	6166	1226	2363	
	8 Blank but applicable	27	2	17	
	Blank	1139	100	385	

Position	Item description and code	Counts M	C	P	Source and notes
803	**Back-lumbar spine limitation of motion-left rotation**				
	1 Yes	127	28	69	
	4 No	6169	1227	2363	
	8 Blank but applicable	27	2	17	
	Blank	1139	100	385	
804	**Back-cervical spine limitation-flexion**				
	1 Yes	8	8	6	
	4 No	6303	1249	2432	
	8 Blank but applicable	12	0	11	
	Blank	1139	100	385	
805	**Back-cervical spine limitation-extension**				
	1 Yes	14	10	12	
	4 No	6296	1247	2426	
	8 Blank but applicable	13	0	11	
	Blank	1139	100	385	
	GAIT (POSITIONS 806-808)				
806	**Gait-simple walking (ages 3 years and over)**				
	1 Abnormal	194	21	27	
	4 Normal	6555	1273	2565	
	8 Blank but applicable	13	1	11	
	Blank	700	62	231	
807	**Gait-bowed legs**				
	1 Yes	47	13	11	
	4 No	7252	1325	2737	
	7 Extremity missing or immobilized	10	0	0	
	8 Blank but applicable	18	7	16	
	Blank	135	12	70	
808	**Gait-knock knees**				
	1 Yes	44	0	5	
	4 No	7251	1338	2741	
	7 Extremity missing or immobilized	10	0	0	
	8 Blank but applicable	22	7	18	
	Blank	135	12	70	
	VARICOSE VEINS (POSITIONS 809-810)				
809	**Varicose veins-right leg**				
	1 Severe	24	2	2	
	2 Moderate	107	13	24	
	3 Mild	464	77	104	
	4 Normal	6711	1247	2619	
	8 Blank but applicable	21	6	15	
	Blank	135	12	70	
810	**Varicose veins-left leg**				
	1 Severe	36	1	2	
	2 Moderate	115	13	32	
	3 Mild	454	79	88	
	4 Normal	6700	1246	2625	
	8 Blank but applicable	22	6	17	
	Blank	135	12	70	
811	**Blank**				

Position	Item description and code	Counts M	C	P	Source and notes
	HEALTH STATUS (POSITIONS 812-814)				
812	**Health status-physician's assessment of sample person's health**				
	1 Excellent	4916	648	809	
	2 Very good	1687	379	1205	
	3 Good	538	270	579	
	4 Fair	158	45	145	
	5 Poor	21	1	15	
	8 Blank but applicable	7	2	11	
	Blank	135	12	70	
813	**Health status-nutritional status**				See Note 23
	1 Normal	4136	1328	2737	
	2 Abnormal	23	14	12	
	8 Blank but applicable	7	3	15	
	Blank	3296	12	70	
814	**Health status-weight status**				See Note 23
	1 Obesity	866	270	649	
	2 Normal weight	3204	1046	2051	
	3 Underweight	92	25	49	
	8 Blank but applicable	4	4	15	
	Blank	3296	12	70	

Position	Item description and code	Counts M	C	P	Source and notes
	ATTENTION: A MINUS SIGN WAS PLACED IN THE FOURTH POSITION WHEN ONLY 3 DIGITS WERE USED IN THE ICD CODING.				
815	**DIAGNOSTIC IMPRESSIONS (POSITIONS 815-855)**				See Appendix 1.26
	1 None	6312	1103	2266	
	8 Blank but applicable	3	0	2	
	Blank Yes or physician's exam form blank	1147	254	566	
816-819	**Diagnostic impression-ICD Code**				See Appendix 1.26
	0109-9593	1012	242	496	See Note 26
	8888 Blank but applicable	3	0	2	
	Blank	6447	1115	2336	
820	**Diagnostic impression-basis for judgment**				
	1 History	265	86	233	
	2 Physician's exam	234	43	59	
	3 Both	496	112	201	
	8 Blank but applicable	20	1	5	
	Blank	6447	1115	2336	
821	**Diagnostic impression-confidence in assessment**				
	1 Certain	814	158	337	
	2 Likely	141	78	120	
	3 Uncertain	42	5	36	
	8 Blank but applicable	18	1	5	
	Blank	6447	1115	2336	
822	**Diagnostic impression-severity of condition**				
	1 Mild	627	172	283	
	2 Moderate	333	59	178	
	3 Severe	38	10	31	
	8 Blank but applicable	17	1	6	
	Blank	6447	1115	2336	
823	**Diagnostic impression-Has a physician been consulted regarding this condition within the last year?**				
	1 Yes	681	187	392	
	2 No	313	53	50	
	3 Don't know	4	0	52	
	8 Blank but applicable	17	2	4	
	Blank	6447	1115	2336	
824-827	**Diagnostic impression-ICD Code**				See Appendix 1.26
	0119-9599	252	51	144	See Note 26
	V451 Renal Dialysis Status	0	0	1	
	8888 Blank but applicable	3	0	2	
	Blank	7207	1306	2687	
828	**Diagnostic impression-basis for judgment**				
	1 History	74	11	64	
	2 Physician's exam	55	12	16	
	3 Both	119	28	65	
	8 Blank but applicable	7	0	3	
	Blank	7207	1306	2686	

Position	Item description and code	Counts M	C	P	Source and notes
829	**Diagnostic impression-confidence in assessment**				
	1 Certain	185	41	101	
	2 Likely	51	10	34	
	3 Uncertain	10	0	10	
	8 Blank but applicable	9	0	3	
	Blank	7207	1306	2686	
830	**Diagnostic impression-severity of condition**				
	1 Mild	148	35	87	
	2 Moderate	85	10	50	
	3 Severe	15	6	8	
	8 Blank but applicable	7	0	3	
	Blank	7207	1306	2686	
831	**Diagnostic impression-Has a physician been consulted regarding this condition within the last year?**				
	1 Yes	189	44	121	
	2 No	58	7	11	
	3 Don't know	1	0	13	
	8 Blank but applicable	7	0	3	
	Blank	7207	1306	2686	
832-835	**Diagnostic impression-ICD Code**				See Appendix 1.26
	0119-9289	75	12	42	See Note 26
	8888 Blank but applicable	3	0	2	
	Blank	7384	1345	2790	
836	**Diagnostic impression-basis for judgment**				
	1 History	18	3	22	
	2 Physician's exam	20	4	3	
	3 Both	36	5	16	
	8 Blank but applicable	4	0	3	
	Blank	7384	1345	2790	
837	**Diagnostic impression-confidence in assessment**				
	1 Certain	54	8	27	
	2 Likely	17	3	10	
	3 Uncertain	3	1	4	
	8 Blank but applicable	4	0	3	
	Blank	7384	1345	2790	
838	**Diagnostic impression-severity of condition**				
	1 Mild	45	9	26	
	2 Moderate	27	3	14	
	3 Severe	2	0	1	
	8 Blank but applicable	4	0	3	
	Blank	7384	1345	2790	
839	**Diagnostic impression-Has a physician been consulted regarding this condition within the last year?**				
	1 Yes	58	10	34	
	2 No	16	2	5	
	3 Don't know	0	0	3	
	8 Blank but applicable	4	0	2	
	Blank	7384	1345	2790	

Position	Item description and code	Counts M	C	P	Source and notes
840-843	**Diagnostic impression-ICD Code**				See Appendix 1.26
	0119-785C	20	3	14	See Note 26
	8888 Blank but applicable	3	0	2	
	Blank	7439	1354	2818	
844	**Diagnostic impression-basis for judgment**				
	1 History	4	0	5	
	2 Physician's exam	4	1	1	
	3 Both	12	2	8	
	8 Blank but applicable	3	0	2	
	Blank	7439	1354	2818	
845	**Diagnostic impression-confidence in assessment**				
	1 Certain	13	3	10	
	2 Likely	6	0	4	
	3 Uncertain	1	0	0	
	8 Blank but applicable	3	0	2	
	Blank	7439	1354	2818	
846	**Diagnostic impression-severity of condition**				
	1 Mild	10	2	6	
	2 Moderate	10	1	6	
	3 Severe	0	0	0	
	8 Blank but applicable	3	0	2	
	Blank	7439	1354	2818	
847	**Diagnostic impression-Has a physician been consulted regarding this condition within the last year?**				
	1 Yes	14	2	13	
	2 No	6	1	0	
	3 Don't know	0	0	1	
	8 Blank but applicable	3	0	2	
	Blank	7439	1354	2818	
848-851	**Diagnostic impression-ICD Code**				See Appendix 1.26
	0160-6929	4	1	3	See Note 26
	8888 Blank but applicable	3	0	2	
	Blank	7455	1356	2829	
852	**Diagnostic impression-basis for judgment**				
	1 History	1	1	1	
	2 Physician's exam	0	0	1	
	3 Both	3	0	1	
	8 Blank but applicable	3	0	2	
	Blank	7455	1356	2829	
853	**Diagnostic impression-confidence in assessment**				
	1 Certain	4	1	3	
	2 Likely	0	0	0	
	3 Uncertain	0	0	0	
	8 Blank but applicable	3	0	2	
	Blank	7455	1356	2829	

Position	Item description and code	Counts M	C	P	Source and notes
854	**Diagnostic impression-severity of condition**				
	1 Mild	3	0	1	
	2 Moderate	1	1	1	
	3 Severe	0	0	1	
	8 Blank but applicable	3	0	2	
	Blank	7455	1356	2829	
855	**Diagnostic impression-Has a physician been consulted regarding this condition within the last year?**				
	1 Yes	4	1	3	
	2 No	0	0	0	
	3 Don't know	0	0	0	
	8 Blank but applicable	3	0	2	
	Blank	7455	1356	2829	
856	**LEVEL OF REFERRAL**				See Appendix 1.2?
	1 Level I	2	0	0	
	2 Level II	259	55	98	
	3 Level III	7066	1290	2666	
	Blank	135	12	70	
857-860	**Blank**				

SECTION L. NOTES

1. Family Questionnaire Missing

A Family Questionnaire was to be completed for each eligible family in a household with sample persons. However, a few Family Questionnaires are missing. Data records for sample persons in families with missing questionnaires are flagged with a code = 1, and all family data are blank. Data records for sample persons in families with a Family Questionnaire are flagged with a code = 2.

During the Mexican-American portion of the HHANES survey, a Family Questionnaire continuation booklet containing sample person information was lost for one sample person. Therefore, the sociodemographic data for this sample person are missing. The reference person, family composition, income, residence, and household data for this person were obtained from another person in the household.

2. Examination Status

Not all sample persons consented to come to a Mobile Examination Center to participate in the examination phase of the survey. In certain rare instances (less than 0.1%), sample persons who came to the Mobile Examination Centers did not participate in sufficient components of the examination to be considered as "examined." This data field contains code = 1 for those persons who participated fully in the examination phase, and code = 2 for those who did not come to the examination center or who did not satisfactorily complete the examination.

3. Family Number

In HHANES, all household members who were related by blood, marriage, or adoption were considered to be one "family." All sample persons in the same family unit have the same computer-generated family unit code.

4. Head of Family

Relationship of Sample Person to Head of Family (Pos. 44-45)

Each family containing sample persons has a designated "head of family," and the relationship of each sample person to the head of his or her family is coded in tape positions 44-45. The first three categories of this variable describe the "head" of three different kinds of families.

- Code '01' identifies sample persons who lived alone (i.e., "head" of one-person families, no unrelated individuals living in the household).
- Code '02' identifies sample persons who lived only with unrelated persons.
- Code '03' identifies sample persons who were "heads" of families containing at least one other person (whether or not the household included additional families unrelated to the sample person).

Sociodemographic Data (Pos. 100-131)

This data tape includes some sociodemographic data about the head of each sample person's family (Section F). Because there can only be one "head" per family, the data in this section (positions 100-131) are the same for all sample persons in the same family (i.e., with the same family number codes in positions 39-43). If the sample person is the head of his or her family, the data in positions 100-131 are the same as in the corresponding positions in Section E.

5. Observed Race

"Race" was observed by the interviewer for all sample persons actually seen. Rules for classification of observed race were consistent with those used in the NHANES II and the National Health Interview Survey at that time. The categories were coded as follows:

White — Includes Spanish origin persons unless they are definitely Black, Indian or other nonwhite.
Black — Black or Negro.
Other — Race other than White or Black, including Japanese, Chinese, American Indian, Korean, Eskimo.

6. National Origin or Ancestry

The value for national origin or ancestry is based on Item 2c in the Household Screener Questionnaire and was reported by the household respondent for all household members. In the Mexican-American portion of the survey, if "other Latin-American or other Spanish" (code 9) or "Other" (code 0) was recorded and the specified origin was "Spanish-American" or "Spanish (Spain)", a code of 10 or 11, respectively, was assigned. In all three portions of the survey, if more than one category was reported, the first appropriate "Hispanic" code, if any, was assigned (codes 1, 2, 3, 8, 10, or 11 in the Mexican-American portion; codes 6 or 7 in the Cuban-American portion; codes 4 or 5 in the Puerto Rican portion). If none of these codes was recorded, the first category entered was coded.

7. Codes for States and Foreign Countries

Code	State or Foreign Country
001	Alabama
002	Alaska
004	Arizona
005	Arkansas
006	California
008	Colorado
009	Connecticut
010	Delaware
011	District of Columbia
012	Florida
013	Georgia
015	Hawaii
016	Idaho
017	Illinois
018	Indiana
019	Iowa
020	Kansas
021	Kentucky
022	Louisiana
023	Maine
024	Maryland

Codes for States and Foreign Countries (continued)

Code	State or Foreign Country
025	Massachusetts
026	Michigan
027	Minnesota
028	Mississippi
029	Missouri
030	Montana
031	Nebraska
032	Nevada
033	New Hampshire
034	New Jersey
035	New Mexico
036	New York
037	North Carolina
038	North Dakota
039	Ohio
040	Oklahoma
041	Oregon
042	Pennsylvania
044	Rhode Island
045	South Carolina
046	South Dakota
047	Tennessee
048	Texas
049	Utah
050	Vermont
051	Virginia
053	Washington
054	West Virginia
055	Wisconsin
056	Wyoming
060	American Samoa
093	Canada
061	Canal Zone
062	Canton and Enderbury Islands
091	Central America
095	Costa Rica
063	Cuba
064	Dominican Republic
065	El Salvador
062	Enderbury Islands
087	Germany
066	Guam
068	Guatemala
069	Haiti
088	Honduras
070	Jamaica
090	Japan
067	Johnston Atoll
080	Mexico
071	Midway Islands
081	Nicaragua
096	Palestine
097	Austria
098	Lebanon
099	Chile
100	Philippines

Codes for States and Foreign Countries (continued)

Code	State or Foreign Country
101	Brazil
102	Holland
103	Colombia
082	Panama
072	Puerto Rico
092	Saudi Arabia
083	Spain
094	Taiwan
089	Turkey
084	Uruguay
085	Venezuela
073	Ryukyu Islands, Southern
074	Swan Islands
075	Trust Territories of the Pacific Islands (includes Caroline, Mariana and Marshall Island groups)
076	U. S. miscellaneous Caribbean Islands (includes Navassa Islands, Quito Sueno Bank, Roncador Cay, Serrana Bank and Serranilla Bank)
077	U. S. miscellaneous Pacific Islands (includes Kingman Reef, Howland, Baker & Jarvis Islands, and Palmyra Atoll)
086	United States
078	Virgin Islands
079	Wake Island
104	Azores
105	Peru
106	England
107	Vietnam
108	Italy
109	Ecuador
110	North America
111	Surinam
112	Argentina
113	Portugal
114	Trinidad
115	Egypt
116	Sudan
117	British Honduras
118	China
888	Blank but applicable

8. National origin recode

In the HHANES, if any household member was identified as "Hispanic" (as defined below), all household members, regardless of origin, were eligible to be selected as sample persons. The national origin recode specifies whether a sample person is considered to be "Hispanic" or "not Hispanic" for purposes of analysis. "Hispanic" is defined as:

Mexican-American in the Southwest portion of the survey;
Cuban-American in the Dade County, Florida portion; or
Puerto Rican in the New York City area portion.

The recode was assigned as follows:

A. Southwest portion

1) If the original national origin or ancestry code on the Household Screener Questionnaire was 1, 2, 3, 8, 10, or 11, then National origin recode = 1;

2) If national origin or ancestry was 4, 5, 6, 7, 9, or 0 but the person specified Mexican/Mexicano, Chicano, or Mexican-American self-identification on the Adult Sample Person Questionnaire (question M10), or the person was the biological child of a household member with Recode equal to 1 (as determined by questions A-1/A-11 on the Family Questionnaire), then National origin recode = 1;

3) In all other cases, National origin recode = 2.

B. Dade County, Florida portion

1) If the original national origin or ancestry code was 6 or 7, then National origin recode = 1;

2) In all other cases, National origin recode = 2;

C. New York City area portion

1) If the original national origin or ancestry code was 4 or 5, then National origin recode = 1;

2) If national origin or ancestry was 1, 2, 3, 6, 7, 8, 9, or 0 but the person specified Boricuan or Puerto Rican self-identification on the Adult Sample Person Questionnaire (question M10), or the person was the biological child of a household member with Recode equal to 1 (as determined by questions A-1/A-11 on the Family Questionnaire), then National origin recode = 1;

3) In all other cases, National origin recode = 2;

The national origin recode may be used in analysis in one of two ways:

a. Selecting on Recode = 1 will restrict analysis to "Hispanics" only. In this case, in the Southwest portion of the survey, the weighted estimates by age and sex will approximately equal U.S. Bureau of Census population estimates of the number of Mexican Americans and a small proportion of other Hispanics assumed to be Hispano in the five Southwest States (Arizona, California, Colorado, New Mexico, and Texas) at the midpoint of the Mexican-American portion of HHANES - March 1983. The weighted estimates of Cuban Americans represents an independent estimate of the number of Cuban Americans in Dade County at the midpoint, February 1984. The weighted estimates of Puerto Ricans represents an independent estimate of the number of Puerto Ricans in the sample counties in New York, New Jersey, and Connecticut at the midpoint of the Puerto Rican portion--September 1984.

b. Using Recode greater than 0, that is, all sample persons, will include "Hispanic" and "not Hispanic" persons and the Southwest weighted estimates by age and sex will overestimate the U.S. Bureau of the Census population estimates of Mexican Americans and other Hispanics by about 4.5 percent. In Dade County, using recode greater than 0 will increase the weighted estimates by about 5.3 percent over that for Cuban Americans only, using recode greater than 0 for the New York area will increase the weighted estimates by about 9.2 percent over that for Puerto Ricans only.

9. Industry and Occupation Code

Family Questionnaire questions B-12 through B-15 (see page 117 or 139 of Ref. No. 1 in Section C) identified sample persons 17 years old or older who were in the labor force working for pay at a job or business or who worked without pay in a family business or farm operated by a related member of the household without receiving wages or salary for work performed.

Questions B-17 through B-22 provided a full description of sample persons' current or most recent job or business. The detail asked for in these questions was necessary to properly and accurately code each occupation and industry. Interviewers were trained to define a job as a definite arrangement for regular work for pay every week or every month. This included arrangements for either regular part-time or regular full-time work. If a sample person was absent from his or her regular job, worked at more than one job, was on layoff from a job or was looking for work during the two week reference period, interviewers were trained to use the following criteria to determine the job described:

a. If a sample person worked at more than one job during the two week reference period or operated a farm or business and also worked for someone else, the job at which he or she worked the most hours was described. If the sample person worked the same number of hours at all jobs, the job at which he or she had been employed the longest was entered. If the sample person was employed at all jobs the same length of time, the job the sample person considered the main job was entered.

b. If a sample person was absent from his or her regular job all of the two week reference period, but worked temporarily at another job, the job at which the sample person actually worked was described, not the job from which he or she was absent.

c. If a sample person had a job but did not work at all during the two week reference period, the job he or she held was described.

d. If a sample person was on layoff during the two week reference period, the job from which he or she was laid off, regardless of whether a full-time or part-time job, was described.

e. If a sample person was looking for work or waiting to begin a new job within 30 days of the interview, the last full-time civilian job which lasted two consecutive weeks or more was described.

The 1980 census of population Alphabetical Index of Industries and Occupations was used in the coding of both industry and occupation. This book has Library of Congress Number 80-18360, and is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 for $3.00. Its Stock Number is 003024049-2.

10. Health Insurance

a. In the Health Insurance section of the Family Questionnaire, up to three separate health insurance plans could be reported for a family. Each sample person could have been covered by any combination of the three, or by none at all. In order to simplify the health insurance coverage data, the information on all reported plans was combined to a single variable for each sample person, i.e., whether or not the person is covered by any plan (position 74). For all persons covered by at least one plan, information on the type of coverage is then indicated: position 75 specifies whether any of the sample person's plans pays hospital expenses and position 76 specifies whether any of the sample person's plans pays doctor's or surgeon's bills.

b. For all sample persons who were not covered by Medicare or any health insurance plan, the reasons for not being covered were ascertained. Positions 77-78 contain the main or only reason reported. For persons with one or more additional reasons, the first (lowest) code entered on the questionnaire was coded in positions 79-80.

11. Per Capita Income

Per capita income was computed by dividing the total combined family income by the number of people in the family.

12. Poverty Index

The poverty index is a ratio of two components. The numerator is the midpoint of the income bracket reported for each family in the Family Questionnaire (E-11). Respondents were asked to report total combined family income during the 12 months preceding the interview. The denominator is a poverty threshold which varied with the number of persons in the family, the adult/child composition of the family, the age of the reference person, and the month and the year in which the family was interviewed.

(Note 12 continues on next page)

Poverty thresholds published in Bureau of the Census reports* are based on calendar years and were adjusted to reflect differences caused by inflation between calendar years and 12 month income reference periods to which question E-11 referred. Average Consumer Price Indexes for all Urban consumers (CPI-U) for the calendar year for which the poverty thresholds were published (see table below) and for the 12 months representing the income reference period for the respondent were calculated. The percentage difference between these two numbers represents the inflation between these two periods and was applied to the poverty threshold appropriate for the family (based on the characteristics listed above). For example, for a family interviewed in November, 1983, the 1982 poverty threshold was updated to reflect inflation by multiplying by the percent change in the average CPI-U for the 12 month reference period, which would have been November, 1982 through October, 1983, over the calendar year January through December, 1982, in this example. To compute poverty indexes, the midpoint of the total combined family income bracket was divided by the updated poverty threshold.

Average Consumer Price Index, all Urban consumers (CPI-U), U. S. city average, 1981-84

Month	Year			
	1981	1982	1983	1984
January	260.5	282.5	293.1	305.2
February	263.2	283.4	293.2	306.6
March	265.1	283.1	293.4	307.3
April	266.8	284.3	295.5	308.8
May	269.0	287.1	297.1	309.7
June	271.3	290.6	298.1	310.7
July	274.4	292.2	299.3	311.7
August	276.5	292.8	300.3	313.0
September	279.3	293.3	301.8	
October	279.9	294.1	302.6	
November	280.7	293.6	303.1	
December	281.5	292.4	303.5	
Average	272.4	289.1	298.4	

Source: U.S. Department of Labor, Bureau of Labor Statistics

* U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 138, "Characteristics of the Population Below the Poverty Level: 1981", U.S. Government Printing Office, Washington, D.C., March 1983.

U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 144, "Characteristics of the Population Below the Poverty Level: 1982", U.S. Government Printing Office, Washington, D.C., March 1984.

Members of families with incomes equal to or greater than poverty thresholds have poverty indexes equal to or greater than 1.0 and can be described as "at or above poverty"; those with incomes less than the poverty threshold have indexes less than 1.0 and can be described as "below poverty".

Poverty thresholds used were computed on a national basis only. No attempt was made to adjust these thresholds for regional, State, or other variations in the cost of living. None of the noncash public welfare benefits such as food stamp bonuses were included in the income of the low income families receiving these benefits.

13. Size of Place and SMSA

Codes for size of place and SMSA were obtained from Bureau of Census summary tape files (STF1B).

A place is a concentration of population. Most places are incorporated as cities, towns, villages or boroughs, but others are defined by the Bureau of the Census around definite residential nuclei with dense, city-type street patterns, with, ideally, at least 1,000 persons per square mile. The boundaries of Census defined places may not coincide with civil divisions.

A Standard Metropolitan Statistical Area (SMSA) is a large population nucleus and nearby communities which have a high degree of economic and social integration with that nucleus. Generally, an SMSA includes one or more central cities, all urbanized areas around the city or cities, and the remainder of the county or counties in which the urbanized areas are located. SMSAs are designated by the Office of Management and Budget.

The same place size and SMSA codes were assigned to all persons in the same segment (for the definition of segments see Ref. No. 1 in Section C). In a few cases segments were divided by place boundaries. In these cases codes were assigned after inspecting segment maps. If the segment was predominantly in one place, then the place code for that place was used. If the segment was approximately evenly divided, the code for the larger place was used.

14. Home Heating

Questions E-3 through E-6, pertaining to the main fuel and equipment used for heating the home, appear to have codes which are inconsistent. It has been verified that these are the codes that were recorded on the original document; that is, codes that appear inconsistent were not incorrectly keyed.

15. Blank Records

In this field a "1" indicates respondents who were included in the sample, but did not receive a physical exam. Although positions 407-860 are blank, demographic data are available for these respondents.

16. Ear Drum and Eye

The blank code has one of two meanings:

1) the respondent did not undergo a physical exam and consequently all fields 407-860 are blank (see note 16); or

2) the ear drum was adequately visualized or the eye was present.

17. Fundus

The fundus was not visualized either due to physical reasons, e.g. cataract, or lack of patient cooperation.

18. Blood Pressure

The fifth Korotkoff sound was used for the diastolic reading.

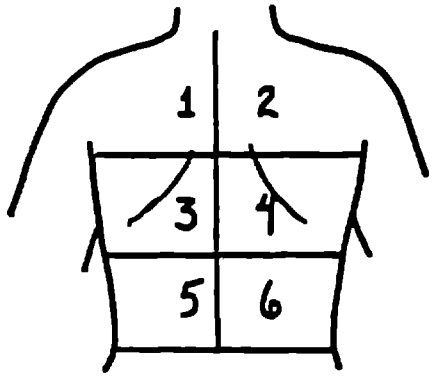
Sections 1.10 through 1.10.2 contain a complete description of the techniques employed in the blood pressure readings.

The use of enhancement methods for increasing the loudness of the blood pressure sounds, as described in the Appendix, is not reported on the tape.

Before using this data for analytic purposes, it is advisable to ascertain the effects of examiner differences and digit preference.

19. Chest

The chest was divided into six (6) areas to facilitate reporting of physical findings.

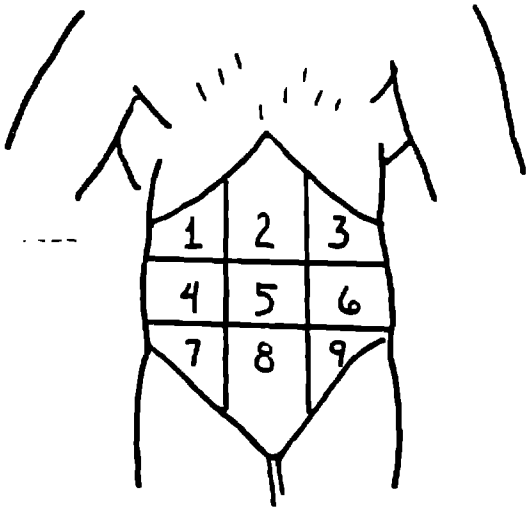


20. Breast

Code 4 includes women with mastectomies.

21. Abdomen

The abdomen was divided into nine (9) areas to facilitate report of physical findings.



22. Uterus

Code 4 includes women with hysterectomies. Males have a blank code.

23. Added Questions

These questions were not included during the first six locations of the Mexican-American portion of the survey.

24. Extremities

Code 7 indicates either a missing or immobilized limb. The form was not designed to identify all missing or immobilized limbs.

25. Joints

Code 1 indicates no abnormality in the present, non-immoblized joints. Code 7 indicates both joints are missing or immobilized. Code 8 indicates either data was not obtained on both joints or data was not obtained on one joint and the other joint was missing or immobilized. A blank has one of three meanings:

1) respondents with entire physician's exam form blank;

2) individuals less than 10 years of age; or

3) abnormality in at least one joint.

26. ICD Code

A minus sign was placed in the fourth position when only 3 digits were used in the ICD coding.

APPENDIX: EXCERPTED FROM THE PHYSICIAN'S EXAMINATION PROCEDURES MANUAL (Ref. No. 12)

1.1 Introduction

The objectives of the Hispanic HANES are to produce and publish health and nutritional data required to assess the status of nutrition, health and health care of Hispanics who are between the ages of six months and 74 years. All procedures, tests and measurements will be carried out in an objective, uniform and standard manner. Data from this study will be appropriate for the following major uses:

- To compare to the data collected in previous NHANES;
- To create a baseline of statistical information on nutrition and certain chronic diseases which can be used for comparison with corresponding information to be gathered in future studies; and
- To produce data which generate reliable health status estimates of the three major Hispanic subgroups, Mexican-Americans, Puerto Ricans, and Cuban-Americans.

In order to fulfill these purposes, the physician's examination must be conducted and recorded in as uniform a manner as possible. Instead of the general clinical examination performed in the manner familiar to examining physicians, this is a physical examination which is highly structured in order to collect consistent data on conditions pertinent to nutrition and certain chronic diseases. This is an examination designed to obtain information that is objective, measurable, and related to specific major physical diseases and defects. Neither the survey objective nor the structure and flow of the examination allow for definitive diagnosis. They do require consistency and speed for coordination with other examinations and measurements carried out in the MEC. This chapter of the manual provides the specific procedures to be followed for conducting and recording the examination.

1.2 Approach to Training

HHANES is an epidemiologic study. It is designed to determine the prevalence of certain diseases in the Hispanic population in the United States. Since its purpose is epidemiologic rather than diagnostic, the criteria used to determine a particular symptom or clinical sign may differ from those used in clinical practice.

However, since these data will be compared with data collected in the future to determine trends in the prevalence of disease and nutritional status, it is critical that explicit definitions and criteria be used and that these criteria be documented so that they can be used in the future. Otherwise, differences found over time in the prevalence of disease that might be attributed to changes in nutritional status may actually be due to differences in criteria used. Similarly, because different examiners will be conducting the exam it is critical that they all use the same procedures and criteria. Otherwise, differences found between age groups or geographic locations may actually be due to examiner differences.

The training of the physicians involved in conducting and recording results of the physical examinations has a dual purpose. First, it provides the standardized methods for the examination; and second, it provides a consistent base of information for review of relevant physical examination procedures and definitions of physical conditions.

We have tried to stress those areas of the examination with which examiners may have had less experience. For example, heart sounds, particularly the identification and classification of murmurs, are described in detail. The WHO classification of goiters is described. Standardized blood pressure measurement techniques are stressed.

As in other epidemiologic studies, it is essential that the instructions for collection of information be clearly and completely presented and that these instructions be followed exactly.

1.3 Examination Goals and Format

The physician's examination for the survey has two goals:

- To obtain information on the presence or absence of the physical signs listed on the form; and
- To list and code conditions indicated by the physician's examination and the history.

The Physician's Examination Form is central to the Hispanic HANES data collection process. Several aspects of data collection should be considered before specifications for the completion of the form are discussed. There are two sources of error that may enter into a sample survey, sampling error and nonsampling error. The sampling error, error due to making measurements on a sample rather than on the entire population, can be quantified and is the concern of statisticians in sample survey design. Of equal importance is nonsampling error which is introduced during data collection and processing. Quality control centers on the control of nonsampling errors. Much time and effort in the HHANES will be invested in reducing nonsampling error and collecting data of high quality. Because examiners may inadvertently introduce variability and bias, all MEC examiners will be trained to conduct examinations and reach findings using standardized procedures and indices.

Just as uniformity and standardization are important in performing the procedures of the examination, these same characteristics are vital in recording the observations or measurements. Accuracy and precision again are important, as well as an additional characteristic — legibility. An entry that cannot be read is lost data.

There will be some unavoidable loss of data; for example, X-rays will be contraindicated for some examinees, and children may not cooperate for certain procedures. The examining staff are expected to use discretion regarding these unavoidable losses, to stop procedures occasionally when it is apparent that examinees cannot cooperate. It is the avoidable loss of data that is the responsibility of each staff member to prevent.

General specifications for completing the Physician's Examination Form are as follows:

- Before the examination session begins, review the medical histories (the Sample Person Questionnaires) for all persons scheduled to be examined during the session and make any necessary notes. There are two versions of the questionnaire; one is for adults 12-74 years old and one is for children 6 months-11 years. They are printed on colored paper, yellow for adults, blue for children. If there are any significant findings, or questions, these may be reviewed with the examinee for additional clarification or amplification. The Sample Person Questionnaire contains numerous sections. The most significant sections for the physician to review are the Health Services, the Conditions List, and the Medically Prescribed Drug List. See Exhibits 1-1 and 1-2 for a summary of the medical history items to review. Return the Sample Person Questionnaires to the Supplement Interviewer who will use them during the session.

- Fill out the Physician's Examination Form completely. There are 13 pages to the form. There are five additional forms used for tracking and documenting aspects of examination procedures.

- Enter all information using a No. 2 black pencil. If an incorrect entry is made, circle the incorrect answer and fill in the correct response. Accuracy of the data is the most important consideration. Print legibly and do not use medical shorthand.

- Note that the format of the form is similar to a check list in which the presence or absence of specific conditions and basic descriptive items are noted. Also, there is space to describe any additional findings or to expand on checked findings within each subsection of the form.

Exhibit 1-1. Summary of Medical History Items from the Child Sample Person Questionnaire, Ages 6 Months - 11 Years

PAGE	QUESTION	TOPIC
1	A 11, 12, 13	Birth
2	B 1, 3, 4	Health Services
4	B 14	
5	B 22	
6	B 28	
7	B 35, 36	
8	C 9-12	Dental and Anemia
8	D 1, 5, 6	Vision and Hearing
9	D 14, 15-21	
10	D 29	
10	E 1, 2, 5, 6	TB/Weight/Immunization/Pesticides
12	F 2-9	Functional Impairment
13	F 10-14	
14	G 1-4, a-n	Condition List
16	H 5-7	School Attendance and Language Use
21	K 5	Medicine/Vitamin Usage
22	K 6	
28	M 8, 9-13	Sample Child Self-Response
29	N 1, 2	Medicine/Vitamin MEC

Exhibit 1-2. Summary of Medical History Items from the Adult Sample Person Questionnaire, Ages 12-74 Years

PAGE	QUESTION	TOPIC
1 2 3 4 6	A 1-6 A 9, 14 A 17, 21 A 27 A 33-35	Health Services
6	B 1-6	Selected Conditions
8-10	C 1-27	Diabetes
10 11	D 1-7 D 11-17	Vision and Hearing
11 12 13 14	E 1-3 E 7, 8 E 22, 23 E 25-28	Hypertension
14-17	F 2-35	Gallbladder Disease
18-20	G 1-21	Cardiovascular Conditions
20	H 2-5	Smoking
22-25	J 2-42	Functional Impairment
25	K 1-3	Conditions List
35 36	P 5 P 6	Medicine/Vitamin Usage
43	R 1, 2	Medicine/Vitamin MEC

- Notice that certain procedures are to be deleted from the examination on the basis of the age of the examinee. Leave the item on the form blank when the procedure is deleted due to age. These procedures are indicated on the form and are listed below:
  - Blood pressure - only measured on persons six (6) years and older.
  - Breast mass(es) - only examined for persons ten (10) years and over.
  - P.M.I. - only measured on persons eighteen (18) years and older.
  - Gallbladder questions - only asked of examinees who are given the ultrasound examination.
  - Tanner Staging - only determined on examinees between the ages of ten (10) and seventeen (17).
  - Ortolani's Maneuver - only performed on examinees less than age three (3).
  - Joints - only performed on examinees ten (10) years and over.
  - Epiphysial enlargement, wrists - only examined on persons under age eighteen (18).
  - Straight leg raising test - only performed on examinees age eighteen (18) and over.
- In some cases certain parts of the examination will not be applicable. This will occur when, for example, the examinee has had the part of the body removed that is to be examined. Since there is no code on the form for these situations, write N.A. to the immediate right of the appropriate "No" box but not inside the box.
- If the examinee is uncooperative (for example, is a crying child), or cannot perform some portion of the examination (for example, is an eight month old infant who cannot walk and cannot have gait evaluated), then make a note in the column on the right side of the form and leave the coding boxes blank.
- Notice that the position of the examinee for each procedure is stated on the form.
- Record positive findings as soon as they are discovered. The physician does not have to stop to record any normals until the next recording point. If the examinee has no abnormal findings the points for recording are:
  - just before the first pulse and blood pressure measurement,
  - after completing the first pulse and blood pressure measurement,
  - after completing the heart examination,

- just before the second pulse and blood pressure measurement,
- after completing the second pulse and blood pressure measurement,
- after checking the gait of the examinee at the end of the exam.

o Complete the form while the examinee is in the examining room to allow for any necessary corrections.

In this section of the manual, instructions for conducting the examination are organized as follows:

o 1.x - Body Part or System,

o 1.x.1 - Procedure -- explaining the position of the examination and how to examine the particular body part or system, and

o 1.x.2 - Recording of Findings and Definitions -- explaining how to complete the form and giving criteria for the conditions listed on the form.

This format is used for the remainder of this chapter.

1.4 Examinee Identification

1.4.1 Procedure

This information appears on the Control Record. It should be the same as that for the Sample Person Questionnaire and for the Control Record and it should be verified. The sample number is stamped on the bottom of the form.

1.4.2 Recording of Findings and Definitions

o Examiner No. - Insert your three digit identifier.

o Reviewer No. - Leave blank.

o Copy the following from the Control Record and verify with examinee:

- Age - Month or years. Record in months if examinee is less than twelve months old; record in years if one year old or older. Use the age on the household interview day.
- Sex - Check the appropriate box, Male or Female.

1.5 Skull and Ears

1.5.1 Procedure

With examinee seated, inspect skull for bossing. Examine right ear first and then left ear:

o Inspect external ear and canal for discharge, swelling or redness.

- o Inspect ear canal and eardrum using an otoscope. Use the largest speculum the examinee's ear canal will accommodate.

- o Inspect ear drum fully by sliding speculum slightly down and forward. Check color, shape and position of ear drum.

1.5.2 Recording of Findings and Definitions

- o Bossing of skull - Record abnormal prominence or protrusion of frontal or parietal areas by checking "Yes" box. If normal, check "No."

- o Check "Right" and/or "Left" ear under "Otitis Externa" if evidence of inflammation is found in external ear canal. Check "No" if both canals are normal.

- o If there is a "Purulent discharge," check "Right" and/or "Left" as appropriate. If abnormality is not found in either ear canal, check the "No" box.

- o Under Ear Drums, check "Not visualized, canal completely occluded" in the right and/or left ear if the canal is totally sealed by cerumen or any other substance and skip to A4 to give the reason for the occlusion. This item will be used in interpreting the Tympanic Impedance Test results.

- o Check "Not visualized, other" in right and/or left ear if there is not sufficient tympanic membrane visible to characterize the membrane. For positive responses skip to A4 and write the cause of the obstruction under "Other."

- o Check as many structured responses as apply in the description of the membrane, e.g., "Dull," "Bulging," and "Fluid" may all be checked under right ear. If there is a healed perforation check "Right" and/or "Left" under "Scars" as appropriate. If abnormality is not found in either ear drum check the "No" box for each condition. If the membrane is perforated, check either "With discharge," or "Without discharge."

- o "Fluid" refers to an observable level of fluid behind the ear drum.

- o "Transparent" refers to an abnormally thin ear drum.

- o Write in under "Other" a description if the structured responses for the skull, auditory canal, and tympanic membrane need to be supplemented. Describe any causes of obstruction, e.g., cerumen, foreign body, discharge, or swelling.

1.6 Nares

1.6.1 Procedure

With examinee still seated, examine right naris first, then left:

- o Test patency of each nostril with inspiration (mouth closed) during alternate unilateral occlusion of other nostril.

- Examine vestibule for inflammation and anterior septum for deviation.

- Gently insert the short wide nasal speculum of the otoscope. Inspect mucosa, septum and turbinates for abnormalities.

1.6.2 Recording of Findings and Definitions

- Obstruction is defined as the inability to breathe adequately through a single naris. Check "Right" and/or "Left" naris as appropriate if obstruction is present. If no obstruction is present in either naris check the "No" box.

- For deviated septum check as "Right" or "Left" according to the direction of the deviation.

- Nasal polyps are soft, smooth, pale, movable tumors, usually multiple.

- Check additional boxes "Right" and/or "Left" as appropriate. Check "No" if the abnormality is not found in either naris.

- Describe other significant findings under "Other" such as enlarged adenoids.

1.7 Lips and Pharynx

1.7.1 Procedure

Continue with examinee seated.

- Inspect lips and tongue for symmetry, color, ulcers, fissures or masses.

- Using tongue blade to depress tongue and asking examinee to say "ah" or yawn, look at anterior and posterior pillars and observe tonsils for enlargement, redness or exudate.

1.7.2 Recording of Findings and Definitions

- Check "Yes" box if condition is present. Check "No" box if not.

- Cheilosis - Reddened appearance of lips with fissures at the angles of the mouth.

- Cyanosis of lips - Slightly bluish, grayish, slate-like, or dark purple discoloration of the lips.

- Tonsils are considered enlarged for adults if they protrude one centimeter beyond the fossa. For children, tonsils are considered enlarged if they protrude two centimeters beyond the fossa.

- Describe other findings under "Other" such as abnormality of tongue, buccal mucosa, uvula or parotid glands.

1.8 External Eyes

1.8.1 Procedures

Carry out all eye tests with the examinee seated. If the examinee wears glasses, have them removed for the following examinations. Contact lenses may be left in place.

- Check for strabismus, muscle coordination or imbalance. Cover one eye while examinee looks at light, then uncover it. Note if each eye holds its position or if the eye that was covered swings back into position after being uncovered. Inspect eyelids, conjunctiva and sclera for redness, dryness, or other lesions.
- Inspect cornea of each eye for opacities or other abnormalities.
- Compare size of pupils and check with pen light for pupillary reflex.

With the examinee seated, examine the fundus of each eye using an ophthalmoscope.

- Set ophthalmoscope to 8- diopters.
- Tell examinee to look straight ahead at a specific point on wall.
- Use your right hand and right eye to examine examinee's right eye.
- Place your left hand on examinee's forehead.
- Shine light beam on examinee's pupil.
- Locate red reflex noting any opacities interrupting the reflex.
- Move in toward examinee and when the retina is seen, focus carefully and follow a blood vessel centrally to optic disc.
- Check optic disc for normal color and shape and optic cup-to-disc ratio.
- Follow vessels from disc into each of 4 quadrants.
- Observe relative size of smaller arterioles to larger veins.
- Check for changes such as nicking at arteriovenous crossing.
- Examine surrounding retina for hemorrhages or exudates.
- Lastly, examine macula which is about 2 disc diameters lateral to optic disc.
- Repeat procedures on examinee's left eye using your left eye and left hand with your right hand on examinee's forehead.

1.8.2 Recording of Findings and Definitions

Indicate the presence of any of the following by checking the appropriate "Yes" box. If not present, check the "No" box for that condition.

- Strabismus (squint) - A disorder in which optic axes cannot be directed to same object, due to lack of muscular coordination. Check "Yes" box if test is positive (eye moves into position when uncovered) or if there is an obvious squint. Check "No" box if no abnormality in muscle imbalance is seen.
- Conjunctival injection (bilateral) - Generalized increase in the vascularity of the bulbar conjunctivae in the absence of obvious infection.
- Pale conjunctiva - Conjunctivae do not show the normal brightness and color, usually associated with anemia.
- Xerophthalmia - Xerophthalmia is recorded when the bulbar conjunctiva and cornea are dry and lusterless with a decrease in lacrimation. It is rarely associated with evidence of infection but in extreme cases is associated with keratomalacia.
- Keratomalacia - Corneal softening with deformity, either localized (usually central part of lower half of cornea) or total.
- Pterygium - Triangular thickening of the bulbar conjunctiva.
- Corneal lesions - Any such lesions of the cornea as abrasions, ulcers, thickening, or opacities. Check the box corresponding to the eye(s) involved or the "No" box if not present.
- Unequal pupils - Check larger pupil if pupils are of unequal size or "Equal" if they are the same size.
- Pupillary light reflex - Check normal if on shining the light into the eye the iris contracts quickly and equally for both eyes, resulting in a smaller pupil. The pupil should return to normal quickly after light is removed.
- Record positive findings by checking "Right" and/or "Left" box for each condition noted. Check "No" box if the condition is not present in either eye.
- Globe absent - Recorded when the eye has been enucleated, regardless of the presence or absence of a prosthesis. If globe is present but examinee is blind in that eye note in "Other."
- Red reflex - Through the ophthalmoscope, pupils appear to be red at a distance of one foot from the eye. If the red reflex is decreased or abnormal, check the box corresponding to the eye involved. If the red reflex is normal (that is, not decreased) check the "No" box.
- Lens opacities - Well advanced cataracts appear as gray opacities in the lens. They will be seen with the ophthalmoscope held about 12 inches away. Small ones stand out as dark defects in the red reflex. A large cataract may obliterate the red reflex.

- Papilledema (choked disk) - A swelling of the nerve head from increased intracranial pressure or interference with venous return from the eye. It is usually bilateral.

1.9 Neck

1.9.1 Procedure

Continue with examinee seated.

- Palpate the neck lymph nodes in the following areas:
  - In front of and behind the ear,
  - Occipital,
  - Submental,
  - Submaxillary,
  - In front of and behind the sternocleido-mastoid muscle, and
  - Supraclavicular.
- Inspect and palpate the thyroid gland for goiter as follows:
  - Stand in front of the examinee,
  - Observe the neck for thyroid gland visability with head in normal position and then have examinee extend his neck to expose the thyroid area by tipping his chin upward,
  - For each of these positions, observe the gland at rest and as the examinee swallows two or three times,
  - Palpate the gland with both hands simultaneously, the fingers on the occiput and the thumbs on the thyroid gland.
  - Palpate at rest and as examinee swallows two or three times for thyroid gland contour, tenderness or nodes.

1.9.2 Recording of Findings and Definitions

- Check "Yes" box as appropriate if abnormality is found. Check appropriate "No" box if abnormality is not present.
- Thyroid gland evaluation - classify size of goiter using the WHO classification as follows:
  - Grade 0 - Persons without goiter. By definition these are persons whose thyroid glands are less than 4 to 5 times enlarged.
  - Grade 1 - Persons with palpable goiters. The thyroid gland is considered to be more than four to five times enlarged although not visible with head in normal position. Most of such glands will be readily visible with the head tilted back and neck fully extended.

- Grade 2 - Persons with visible goiters. Persons with goiters that are easily visible with the head in normal position, but that are smaller than those in Grade 3.

- Grade 3 - The goiters of persons in this category can be recognized at a considerable distance. They are grossly disfigured and may be of such size as to cause mechanical difficulties with respiration and the fit of clothing. Palpation may be helpful in determining the mass of the gland but is not needed for diagnosis.

o Check "Right" and/or "Left" box(es) if tenderness or nodule is found. Check "No" box if either of these conditions is not found.

o Describe other abnormal findings such as tracheal deviation and distended neck veins under "Other."

1.10 Pulse and Blood Pressure Measurement

The pulse and blood pressure will be measured by the physician. Although these tests appear quite simple, accurate and standardized measurements depend on many factors. Because the measurements must be obtained in a uniform manner for each examinee, it is critical that you always follow these procedures.

For examinees who are age six and older the pulse and blood pressure are measured at two specified points in the physician's examination. Both blood pressure measurements are made with the examinee seated. The measurements are taken at specified points during the examination when the examinee is as quiet and undisturbed as possible.

For examinees who are age five and younger only, the pulse is measured. This one measurement should be made at the time when the second blood pressure would be measured for older examinees.

Be sure that the examinee does not smoke or drink coffee during the examination since these could affect the blood pressure. If the examinee has had any alcohol, coffee, or cigarettes thirty minutes before the examination, record this on the form but still take the measurements.

There are some situations where taking the blood pressure is contraindicated. For example, if there are any rashes, bandages, casts, puffiness, paralysis, tubes, open sores or wounds on both arms do not take the blood pressure. If these conditions prevent measuring pulse, do not attempt taking the blood pressure. Give the reason why the blood pressure cannot be taken on the form.

The blood pressure is to be measured in the right arm. If the examinee indicates any reason (such as needles or tubes in the arm during the last week) why this procedure should not be done in the right arm, use the left.

1.10.1 Procedure

There are five parts to the pulse and blood pressure measurement. These are:

- o Locate the pulse points,
- o Select and apply the cuff,
- o Determine the maximum inflation level,
- o Measure the pulse, and
- o Determine the blood pressure.

Each of these is described below. For each of the procedures the arm should be placed at the level of the fourth intercostal space. The arm should be supported by the adjustable instrument table which should be elevated to the height necessary to bring the arm to this level.

1.10.1.1 Locate the Pulse Points

- o Locating the radial pulse: With the examinee's right palm turned upward, place the first two fingers of your hand on the outer part of the crease of the wrist.
- o Locating the brachial pulse: Again, with the right palm of the examinee turned up, and the arm straightened (slightly bent at the elbow), place the first two fingers of your hand on the innermost (side toward the body) part of the crease of the elbow. If the brachial pulse is not felt, move your fingers slightly closer to the center of the arm, again press firmly in and hold. Continue this to the center arm. If the brachial pulse is still not felt, begin again from the center of the arm and work your way to the innermost (toward the body) part of the crease of the elbow.
- o Both pulse and blood pressure will be measured in the same arm. The right arm will always be used unless specific conditions prohibit its use. Use the following guidelines:
  - If the radial pulse is apparent, whether or not the brachial pulse can be felt, proceed with the measurement of the pulse.
  - If the radial pulse cannot be felt in the right arm, use the left arm.
  - If the radial pulse cannot be felt in either arm, terminate the pulse and blood pressure procedure and note this on the form.

1.10.1.2 Select and Apply the Cuff

- Select the proper cuff size. The five cuffs to be used are the infant cuff, child cuff, adult cuff, large arm cuff, and thigh cuff. The size of the cuff and bladder used influences the accuracy of the blood pressure readings. If the cuff is too narrow, the blood pressure reading will be too high, and if it is too wide, the reading will be too low when compared to measurements taken intra-arterially. The size of the arm, not the age, determines the size cuff used.

  The inside of the cuff is marked with an index line and range lines. If the index line along the edge of the cuff fits completely within the range lines inside the cuff, the cuff is the correct size. If the cuff is barely large enough, the next larger cuff will be used. If no cuff fits, the blood pressure will not be measured.

  Each cuff size will have a complete inflation system. These are easily attached by a twist connection to the manometer. It will not be necessary to exchange inflation bulbs and valves with the various cuffs.

- After locating the pulse points, apply the cuff to the examinee's arm. Observe the examinee's arm and begin with the cuff that appears appropriate. Check the size before applying the cuff by making sure that the index line falls completely within the range lines. If the cuff is barely large enough, use the next larger size. The procedure for applying the cuff is as follows:

  - In selecting the proper cuff size, check the index line to determine if it lies completely within the size range lines marked on the cuff.

  - Position the rubber bladder over the brachial artery at least one inch above the natural crease across the inner aspect of the elbow. Place the marker on the inner part of the cuff directly over the brachial artery.

  - Wrap the cuff smoothly and snugly around the arm in a circular manner. No spiral direction of the cuff should be used.

  - Check the fit by placing both thumbs under the cuff and tugging gently.

  - For very large arms use the thigh cuff. Wrap the thigh cuff around the upper arm, not the thigh. If the thigh cuff covers the brachial artery at the arm crease, do not measure the examinee's blood pressure.

  - If a proper fit cannot be obtained with any of the cuffs, do not measure the blood pressure. Explain the reason to the examinee and note the problem on the form.

1.10.1.3 Determine the Maximum Inflation Level (MIL)

To measure the maximum inflation level (MIL), connect the inflation tubing to the manometer by twisting the two ends of the tubing together. The MIL is obtained to determine the highest level to which the cuff should be inflated. If the cuff is underinflated and the examinee has an auscultatory gap, a falsely low reading will result. If the cuff is overinflated a falsely high reading could result.

The MIL will then be determined as follows:

- Locate the radial pulse pressure point in the arm to be used.
- Close the thumb valve. Palpate the radial pulse and watch the center of the mercury column of the manometer.
- Inflate the cuff quickly to 80 mm Hg, then inflate in increments of 10 mm Hg until the radial pulse disappears noting the reading of the mercury column at that point. Continue inflating the cuff at increments of 10 mm Hg, pausing briefly to make sure the pulse is absent. Continue 30 mm Hg higher to make sure the radial pulse has disappeared.
- Rapidly deflate the cuff by opening the thumb valve completely and disconnecting the tubing.
- The MIL is the reading at the point the radial pulse disappeared plus 30 mm Hg.
- Wait 30 seconds before making a second attempt if the first is unsatisfactory. If the second attempt is unsatisfactory, terminate the procedure and note the problem on the form.

This value is the maximum level to which the cuff should be inflated for measuring this examinee's blood pressure.

If the examinee reports significant discomfort from the cuff during determination of the MIL, recheck the fit of the cuff and remeasure the MIL. If the discomfort persists, terminate the procedure and note the problem on the form.

If the radial pulse is still felt at a level of 230 mm Hg or higher (MIL 260 mm Hg or higher) repeat the MIL. If the MIL is still 260 mm Hg or higher, terminate the blood pressure measurements and write in "260/MIL" on the Physician's Exam Form. On the Report of Findings I indicate the blood pressure as 230 palpated.

Repeat the MIL if the first attempt was unsatisfactory or you have had to readjust the cuff after measuring the MIL. Wait at least 30 seconds after measuring the MIL and before starting the blood pressure measurement.

When the MIL has been satisfactorily determined, do not remove or reapply the cuff. Wait at least 30 seconds before measuring the blood pressure; during the waiting period take the pulse.

1.10.1.4 Measuring the Pulse

The pulse will be measured by feeling the radial pulse point at the wrist. The pulse measurement should be taken in the interval between the MIL measurement and the blood pressure measurement.

With the elbow and forearm resting comfortably on a stable surface and the palm of the hand turned upward, the radial pulse is felt and counted for 15 seconds exactly. The number of beats in 15 seconds is multiplied by 4, and the result recorded as the pulse on the form.

1.10.1.5 Determine the Blood Pressure

The following procedure will be used for the measurement of blood pressure:

- Position the stethoscope ear pieces comfortably in your ears, turning them forward toward the nose.
- Be sure the examinee's arm is positioned at the level of the fourth intercostal space at the sternum.
- Feel the brachial pulse and place the stethoscope diaphragm directly over the pulse beat just below the cuff. The diaphragm should be applied with light pressure so there is no air between it and the skin. If the brachial pulse is too faint to be felt, place the stethoscope diaphragm over the innermost part of the crease of the elbow and proceed. If possible, avoid allowing the cuff, the tubing or diaphragm to touch. Also avoid allowing the stethoscope to touch the cuff, any tubing, or the gown.
- Close the thumb valve. Rapidly and steadily inflate the cuff to the MIL. (If you inflate the cuff more than 10 mm Hg above the MIL open the thumb valve, rapidly deflate the cuff and disconnect the tubing. Discontinue this reading and wait 30 seconds before inflating again.)
- When the MIL is reached, open the thumb valve and smoothly deflate the cuff at a constant rate near 2 mm Hg per second (one mark per second).
- Be sure your eyes are level with the center of the manometer. Watching the top of the mercury column, note the reading at the point when pulse sounds first appear using the mark at or just above the top (meniscus) of the mercury column. Listen for at least two beats to eliminate recording a single erroneous sound. Note the reading at the point the first pulse sound appears, not at the second beat.
- Continue deflation at 2 mm Hg per second. Note the reading when the sounds finally disappear, using the mark at or just above the top of the mercury column.
- Continue steady deflation at 2 mm Hg per second for at least 20 mm Hg below the second reading; then open the thumb valve completely and disconnect the tubing. Let the cuff fully deflate. If you need to repeat the measurement, wait 30 seconds between measurements.

- Use the first reading (appearance of sounds, first Korotkoff sound) as the systolic pressure and the second reading (disappearance of sounds, fifth Korotkoff sound) as the diastolic pressure. Use the nearest even digit. If the column fell between two digits, use the mark at or just above the top of the mercury column. If pulse sounds continue to be heard down to zero pressure, record the diastolic reading as "000."

- If you have difficulty hearing the blood pressure sounds, there are two methods which can be used to increase the intensity and loudness of the sounds:

  - Have the examinee raise his/her arm and forearm for at least 60 seconds. Inflate the cuff, lower the arm, and take the blood pressure immediately. If raising the arm is difficult for the examinee, use the next method.

  - Instruct the examinee to open and close his/her fist 8-10 times AFTER the blood pressure cuff is inflated to the MIL, but before deflation is begun.

If it was necessary to use one of these enhancement methods make sure you record this fact on the Physician's Examination Form in the space designated for comments.

1.10.2 Recording of Findings and Definitions

For each of the two pulse and blood pressure measurements the same recording instructions apply.

- Record the pulse rate as beats per minute.

- Check the appropriate box to indicate whether or not the pulse was irregular.

- Check the box corresponding to the cuff width used.

- Record the systolic pressure (point when sounds appear) and the diastolic pressure (point when sounds disappear) using the nearest even digit.

- Write in any variation, such as "left arm used," in the space for comments.

- If the pulse and/or blood pressure are not measured, record the reason in the space for comments.

- If the MIL is 260 then you should not take the blood pressure. Write "260" in the space for the systolic pressure and "MIL" in the space for diastolic pressure.

Use the guidelines in Exhibit 1-3 for reporting the blood pressure measurement and MIL to the patient. The examinee should be told his/her blood pressure and what it means. Refer to the "Statement" column of Exhibit 1-3 for the recommended interpretation of the blood pressure reading.

Use good medical judgment and observation when recommending that any action be taken in relation to these findings. Persons with quite high

blood pressures (Exhibit 1-3) should have immediate medical attention. Persons with high blood pressure should see a physician within one week. Persons with above normal reading should see a physician for a recheck of blood pressure within three months.

Exhibit 1-3. Guidelines for Blood Pressure Reporting to Examinees

Systolic		Diastolic	MIL*	Statement
Under 150	and	Under 90		Normal
150 and over	and/or	90-95		Above normal - Recheck within 3 months (Level III Referral)
Any	and	96-114		High - Recheck within 1 week (Level II Referral)
		115 and over	or 260	Quite high - Immediate referral (Level I Referral)

These guidelines are approved by the National High Blood Pressure Coordinating Committee, in the 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, p. 8.

*Maximum Inflation Level

1.11 Chest and CVA

1.11.1 Procedure

Continue with examinee seated.

- o Inspect anterior chest wall paying particular attention to the costochondral junctions, and sternum. Check for asymmetry of chest and observe A.P. diameter.
- o With your hands on examinee's lower ribs and your thumbs together on lower spine ask examinee to take a deep breath. Compare excursion of left and right chest walls.
- o Test for CVA tenderness on right and left using closed fist to elicit response.
- o Auscultate lungs as follows:
  - Listen to posterior chest by asking examinee to breathe in and out through mouth more deeply than usual.
  - Start at apex proceeding downward and from left to right to compare sounds in at least 6 areas (3 on each side).
  - Listen to at least one entire breathing cycle at each location.
  - Listen for timing, pitch, intensity, and quality of breath sounds. Note extra or adventitious sounds.
- o While the examinee is still in a seated position, auscultate the base and apex of the heart for evidence of murmurs using the diaphragm of the stethoscope.

1.11.2 Recording of Findings and Definitions

- o Check "Yes" box if abnormality is present or, as appropriate, indicate severity of condition. Check "No" box if particular condition is not noted. Indicate presence of other abnormalities such as asymmetrical motion of chest under "Other."
- o Beading of ribs - Definitely palpable and visible enlargement of the costochondral junctions.
- o Asymmetry - Check "Yes" if the chest is structurally asymmetrical.
- o Funnel breast - Sternal depression of chest wall resembling a funnel.
- o Pigeon breast - Deformity in which the sternum projects anteriorly.
- o Increased A.P. diameter - A.P. diameter increased to the point of appearing barrel-chested.

- o Auscultation: Circle the number(s) for the area(s) of the lung where abnormality is noted. Diagram of chest is from posterior view.
  - Diffuse wheezing - Harsh breathing with a prolonged wheezing expiration heard all over the chest.
  - Bronchial breath sounds - Harsh breathing with a prolonged high pitched expiration which has sometimes a tubular quality.
  - Rales - Abnormal, crackling respiratory sounds heard on either inspiration or expiration.
  - Ronchi - Dry, course rales in the bronchial tubes.
  - Wheeze - A whistling or sighing sound.

1.12 Breast Mass(es)

1.12.1 Procedure

- o For female examinees age 10 and over - With examinee seated, observe symmetry of size and shape of both breasts, areolae and nipples. With examinee first seated and then supine, palpate the right breast first and then the left breast using a semi-circular method. Begin at the outermost circle and palpate in smaller circles toward the areolae and including the nipple. Compress the nipple.
- o For male examinees age 10 and over - With examinee in supine position, inspect the areolae and nipples for swelling or ulcerations, and palpate for nodules or masses.

1.12.2 Recording of Findings and Definitions

- o Check "Yes" box if nodule or mass is found in "Right" and/or "Left" breast. Check "No" box if none is found.
- o Describe nodule, mass, or other abnormalities under "Other" breast finding, characterizing it with regard to location, size, consistency, tenderness and mobility.

1.13 Heart

1.13.1 Procedure

Continue with examinee in supine position.

- Assess carotid pulse. Assess the right pulse first and then the left pulse:
  - Compress the carotid artery by hooking index and middle fingers around medial edge of sternocleidomastoid muscle.
  - Palpate carotid artery in lower half of neck to avoid carotid sinus.
  - Note amplitude and compare right with left pulse.
  - Auscultate carotid artery for bruits.
- P.I.I. (Point of Maximum Intensity): Inspect chest wall first, then palpate for apical beat. If P.I.I. is felt, determine the closest interspace and its relation to the mid-clavicular line. Skip item 2a and 2b for examinees who are less than 18 years old.
- With the palm of the hand, palpate for thrills at the apex, and at the base.
- Auscultation for murmurs: Start with diaphragm and repeat with bell in following order:
  - Listen at the apex particularly for heart sounds S1 and S3, for systolic click and mitral murmurs.
  - Listen at second right interspace for S2 and aortic murmurs.
  - Listen at second left interspace for S2 and pulmonic murmurs.
  - Listen at third left interspace for S2 and aortic and pulmonic murmurs.
  - Listen just to the left of the ensiform cartilage for tricuspid murmurs.
- Refer to Exhibit 1-2 through 1-4 for location and nature of the lesion.

Exhibit 1-4 Cardiac Murmurs

TIME OF OCCURRENCE	SITE OF GREATEST INTENSITY	DIRECTION OF TRANSMISSION	SEAT OF LESION	NATURE OF LESION
Systolic	At cardiac apex. Use bell of stethoscope	Along left fifth and sixth ribs--in the left axilla--in back, at inferior angle of left scapula	Mitral orifice	Incompetency--Regurgitation
Systolic	At junction of right second costal cartilage with sternum	To junction of right clavicle with sternum--in course of right carotid	Aortic orifice	Narrowing--Obstruction
Systolic	At ensiform cartilage	Feebly transmitted	Tricuspid orifice	Incompetency--Regurgitation
Systolic	At left second intercostal space, close to sternum	Feebly transmitted	Pulmonary orifice	Narrowing--Obstruction
Diastolic	At junction of right second costal cartilage with sternum. Use bell of stethoscope	To midsternum--in course of sternum	Aortic orifice	Incompetency--Regurgitation
Diastolic	At left second intercostal space, close to sternum	In course of sternum	Pulmonary orifice	Incompetency--Regurgitation
(Diastolic) presystolic	Over body of heart	To apex of heart	Mitral orifice	Narrowing--Obstruction
(Diastolic)	At ensiform cartilage	Feebly transmitted	Tricuspid orifice	Narrowing--Obstruction presystolicorifice

1.13.2 Recording of Findings and Definitions

- Diminished carotid pulsations - If pulsations are unequal record the stronger one as normal, the weaker as diminished.

- Carotid bruit - An adventitious sound of arterial origin heard on auscultation. Check "Yes" box if present, "No" box if not.

- P.M.I. (Point of Maximum Intensity) - The point on the chest where the impulse of the left ventricle is felt most strongly, normally in the fifth costal interspace at the mid-clavicular line. Record whether felt or not, and check in which interspace and whether at inside, or outside mid-clavicular line.

- Thrill - A sensation of vibration felt by the examiner on palpation of the heart, for example, over an incompetent heart valve. Check box indicating if present or absent and check the box indicating location.

- Heart sounds: Check the structured responses which best describe:

  - First (S1) - Best heard at apex as dull and prolonged and occurring with the beginning of ventricular systole and closure of mitral and tricuspid valves.

  - Second (S2) - Best heard in second and third left interspaces as short and sharp and occurring with the closure of the aortic and pulmonic valves. A split second sound is sometimes audible at the left sternal border and is due to a slight asynchrony of right and left ventricular contraction.

  - Third (S3) - Best heard at apex as weak, low-pitched and dull following S2. It occurs in most children and in many young adults. It is thought to be caused by vibrations of the ventricular walls when they are suddenly distended by the rush of blood from the atria.

  - Systolic Click - A high pitched brief sound occurring in midsystole and usually loudest at apex.

- Murmurs: Describe all murmurs heard according to when they are heard (systole or diastole), in which area they are heard best, whether they are functional or organic and their intensity.

- The loudness or intensity of a murmur is indicated by a rating system that grades murmurs from 1 to 6:

  - Grade 1 - The softest audible murmur, it is not evident upon initial listening but requires a period of acoustic adjustment or "tuning in."

  - Grade 2 - Faint murmurs but audible without "tuning in."

  - Grades 3 & 4 - Murmurs of intermediate intensity.

- Grade 5 - Murmurs are the loudest but cannot be heard through a stethoscope held off the chest wall.

- Grade 6 - Murmur is so loud as to be audible through a stethoscope held off the chest wall.

o If there are other significant cardiac findings, describe under "Other."

1.14 Abdomen

1.14.1 Procedure

With examinee in supine position:

o Inspect abdomen for swelling, masses, or scars.

o Auscultate abdomen in the aortic, iliac and renal artery areas for bruits.

o Palpate abdomen slowly in all quadrants and in suprapubic areas using a light, dipping motion.

- Note areas of increased resistance or tenderness.

- If there is history of pain or tenderness, palpate that area last.

o Palpate with firm pressure more deeply in all four quadrants to identify masses and tenderness.

o Support the lower rib cage from underneath with your left hand and check with your right hand for enlarged liver:

- Percuss for the lower edge of the liver.

- Place your right hand in right midclavicular line, below lower border of liver dullness.

- Press in and up gently as the examinee inhales deeply.

- Feel for liver edge as it descends and touches your fingertips.

- Reposition your hand if you are unsuccessful or exert more pressure inward as examinee inhales. Note any tenderness.

o Palpate for an enlarged spleen:

- Reach across examinee and support left lower rib cage from underneath the body.

- Place your right hand below left costal margin.

- Ask examinee to inhale deeply and press firmly inwards trying to feel spleen descending toward your fingers.

- If splenic enlargement is suspected, have examinee roll onto right side and repeat procedure.

o During the examination of the abdominal area for examinees who are age twenty and over and are having the gallbladder ultrasound (the fasting group), ask questions that will allow you to answer the following questions (to determine if the examinee has symptoms of gallstones or gallbladder problems):

10a. During the past year has this examinee had any attacks of nausea and/or vomiting lasting more than 2 hours?

10b. During the past five years has this examinee had pain in this area (GALLBLADDER AREA) which lasted a half hour or more?

10c. If "Yes" ABOVE, ASK: Does this examinee usually feel sick to his/her stomach either before or after getting this pain?

11. What is your opinion of the likelihood of this examinee having gallstones?

1.14.2 Recording of Findings and Definitions

o Surgical scars - If scar(s) is/are present, check "Yes" box and circle the number(s) of the area(s) according to diagram.

o Indicate by checking the "Yes" box, the presence of ascites or bruit. If not present, check "No" box.

o Bruit - If bruit is present, check "Yes" box and circle the number(s) of the area(s) according to the diagram.

o Hepatomegaly - If liver is palpated in right upper quadrant, 2 cms or more below right costal margin, indicate as enlarged by checking appropriate "Yes" box.

o Splenomegaly - If spleen is felt in left upper quadrant, check "Yes" box; if not, "No" box.

o Uterine enlargement - Record all enlarged uteri including those enlarged secondary to pregnancy by checking "Yes" box. If not enlarged, check "No" box. Write "N.A." in the right column for males.

o Tenderness, masses in abdomen - Indicate if tenderness and/or masses are found by checking "Yes" box and by circling the number(s) of the area(s) where found (refer to diagram). Circle the number that locates the center of the mass. Write in a description of the mass(es), identifying location, size, shape, whether loose or fixed, firmness, etc.(for example, (7) 3 cm diameter firm, fixed, non-tender).

o Describe any other significant abdominal findings such as hernias under "Other."

1.15 Tanner Staging (Ages 10 through 17)

1.15.1 Procedure

- Skip this section for examinees who are not between the ages of 10 and 17.
- Male - With examinee in supine position inspect pubic hair and genitalia. Inspect and then palpate the testicles.
- Female - With examinee in supine position inspect pubic hair and breasts.

1.15.2 Recordings of Findings and Definitions

- Classify pubic hair (male and female) and check appropriate box according to the following:
  - Stage 1 - Preadolescent. The vellus over the pubis is no further developed than that over the abdominal wall, i.e., no pubic hair.
  - Stage 2 - Sparse growth of long, slightly pigmented downy hair, straight or only slightly curled, appearing chiefly at the base of the penis or along the labia.
  - Stage 3 - Considerably darker, coarser, and more curled. The hair spreads sparsely over the junction of the pubis.
  - Stage 4 - Hair now resembles adult in type, but the area covered by it is still considerably smaller than in the adult. No spread to the medial surface of the thighs.
  - Stage 5 - Adult in quantity and type with distribution in the classically "male" or "female" pattern.

  Note: It is most important to grade genital maturation and pubic hair maturation separately.

- Classify male genitalia and check appropriate box according to the following:
  - Stage 1 - Preadolescent. Testes, scrotum, and penis are of about the same size and proportion as in early childhood.
  - Stage 2 - Enlargement of scrotum and of testes. The skin of the scrotum reddens and changes in texture. Little or no enlargement of penis at this stage.
  - Stage 3 - Enlargement of penis (occurs at first mainly in length). Further growth of testes and scrotum.
  - Stage 4 - Enlargement of penis, with growth in breadth and development of glans. Further enlargement of testes and scrotum; increased darkening of scrotal skin.
  - Stage 5 - Genitalia adult in size and shape. No further enlargement takes place after Stage 5 is reached; it seems, on the contrary, that the penis size decreases slightly from the immediate postadolescent peak.

- Classify female breasts and check appropriate box according to the following:
  - Stage 1 - Preadolescent. Elevation of papilla only.
  - Stage 2 - Breast bud stage. Elevation of breast and papilla as small mound. Enlargement of areolar diameter.
  - Stage 3 - Further enlargement and elevation of breast and areola with no separation of their contours.
  - Stage 4 - Projection of areola and papilla to form a secondary mound above the level of the breast.
  - Stage 5 - Mature stage. Projection of papilla only due to recession of the areola to the general contour of the breast.
- Describe other abnormalities under "Other findings." Record as an undescended testicle only if the testicle cannot be felt either in the inguinal canal or scrotum or if the scrotal development shows no evidence of the testicle ever having descended previously. Retracted testicles due to heightened cremasteric reflex are not to be classified as undescended.
- If breasts are not at the same stage, code the right breast in the boxes provided and code the left in "Other findings."

1.16 Extremities

1.16.1 Procedure

With examinee supine, examine legs and knees for signs of swelling or deformities by carrying out the following:

- Only if examinee is under age 3 - carry out Ortolani's maneuver to check abduction of hips.

  Ortolani's maneuver: With the infant lying supine, the examiner adducts and abducts the legs. The examiner's thumb rests along the inside and the other fingers extend along the outside of the infant's thigh. The hips and thighs are flexed at 90 degrees and one leg is then abducted with the examiner's fingers gently pressing the trochanter of the femur upward and forward. The normal hip in a relaxed infant can be abducted to almost 90 degrees. If dislocation is present, resistance may be felt between 45 and 60 degrees and a click felt as the dislocated femoral head slips into the acetabulum.
- Palpate femoral pulsations simultaneously, and auscultate femoral arteries for presence of bruits.
- Palpate dorsalis pedis pulsations simultaneously.
- Inspect lower extremities for presence of ulcerations.

- o Test for edema by pressing thumb behind medial malleolus, over dorsum of foot and over shin.

- o Only if examinee is eighteen years or older, do straight leg raising test as follows:

  - Raise right leg to a 45 degree angle with knee extended and with foot in normal position,

  - If pain is not elicited, dorsiflex the foot,

  - Repeat with left leg.

  Note: if pain is elicited at any stage in this test, do not continue on that side.

1.16.2 Recording of Findings and Definitions

- o Femoral pulsation - If pulsations are unequal, consider greater one to be normal. Record character of pulsation by checking appropriate box. Check "Yes" box if bruit is present, "No" box if not.

- o Dorsalis pedis pulsations - If pulsations are unequal, consider greater one to be normal. Record character of pulsations by checking appropriate box.

- o Leg ulceration - An open sore with loss of substance, sometimes accompanied by formation of pus. Check "Right" and/or "Left" box if present, "No" box, if not.

- o Edema - Record only if there is indentation of skin or soft tissue (pitting edema) by checking appropriate box:

  - Mild -- Pitting edema over medial malleolus and dorsum only.

  - Moderate — Pitting edema up to mid-tibial line.

  - Severe -- Pitting edema above mid-tibial line.

  - None — If there is swelling but no pitting, record as none.

- o Straight leg raising - Record as "Abnormal" if either straight leg raising test of right or left leg produces pain. Leave appropriate ankle dorsiflexion blank if straight leg raising test of right or left leg produces pain. Check "Yes" box if pain occurs on dorsiflexion of foot. Record as "Normal" and check "No" box if test produces no pain.

- o Describe other abnormalities under "Other."

1.17 Joints

1.17.1 Procedure

If examinee is less than 10 years old skip to Section N.

With examinee in supine position test range of motion of lower extremity in a single movement.

- Ask examinee to bend right knee to chest, placing right foot on left patella. Rotate hip externally and then internally by pulling knee laterally and then medially.
- Repeat with left leg.

With examinee seated, test range of motion of upper extremity in a single movement.

- Ask examinee with arms straight to raise both hands over head, then place both hands behind neck with elbows out, and finally place hands behind small of back.

If examinee is under 18 years of age, inspect wrists for signs of deformity due to epiphysial enlargement.

1.17.2 Recording of Findings and Definitions

- In carrying out range of motion tests observe examinee for evidence of any problems of tenderness, swelling, deformity of the joints, limitation of motion, paralysis or muscle weakness. Check all the boxes appropriate to findings indicating whether condition found is on right, left or both extremities.
- Epiphysial enlargement of wrists - This can be more easily felt than seen and should be recorded by checking the "yes" box, particularly if present at the ulnar epiphysis.
- If pain is elicited on any of the range of motion tests, stop immediately and record findings as much as possible. Under "Other" explain why you stopped range of motion test.
- Specify under "Other" any congenital anomaly, joint injury, prosthesis, amputation, or other joint manifestation.

1.18 Neurological Evaluation

1.18.1 Procedure

With examinee seated, test the following:

- o Coordination
  - Hand-wrist pronation, supination. Ask examinee to hold hands out in front of him and turn them over and back rapidly several times.
- o Sensory
  - Assess vibratory sensation using a tuning fork, asking examinee to tell what is felt and when sensation stops. Test on bony prominence of wrist and ankle on each side.
- o If no weakness is noted while examining the joints or doing the straight-leg raising, assess whether there is generalized muscle weakness or paralysis of arms and legs.
- o Speech evaluation
  - Throughout entire exam, note examinee's oral responses for evidence of stuttering, stammering, or other defects.
- o Tendon reflexes
  - Locate patellar tendon and tap it briskly just below patella to elicit knee jerk. Test both knees.
  - If reflexes are underactive, reinforce by having examinee lock hands and pull.

1.18.2 Recording of Findings and Definitions

- o Coordination - Indicate any uncoordinated movements, or other abnormalities, e.g., tics, tremors, etc., by checking "Abnormal." If no abnormalities noted, check, "Normal."
- o Sensory - Indicate if vibrations are not felt by checking right and/or left boxes as appropriate. If response is elicited and equal check "Normal." If responses are correct check "Normal."
- o Muscles - Check appropriate box if weakness is noted. Identify paralysis and indicate which extremity in space provided.
- o Speech evaluation - Check "Yes" box if speech is abnormal. Use "Stuttering" box if this is noted; all other speech impediments such as slurred speech, lisp, aphasia should be described.
- o Tendon reflexes - "Yes" box is used only if knee reflexes are absent on both sides. If one or both are present check "No" box. If hyperactive or other abnormality noted, describe under "Other."

1.19 Skin Evaluation

1.19.1 Procedure

While conducting the examination, the skin on the arms, legs, and hands and face will have been inspected. If there is need for rechecking any particular area, do it now to complete the evaluation of the examinee's skin.

1.19.2 Recording of findings and Definitions

- Indicate presence of any of the specific skin abnormalities by checking "Yes" box. If not found check "No."

- Follicular hyperkeratosis, of arms and of upper back: This lesion has been likened to "gooseflesh" which is seen on chilling, but is not generalized and does not disappear with brisk rubbing of the skin. Readily felt, it presents a "nutmeg grater" feel. Follicular hyperkeratosis is more easily detected by the sense of touch than by the eye. The skin is rough, with papillae formed by keratotic plugs which project from the hair follicles. The surrounding skin is dry and lacks the usual amount of moisture or oiliness. Differentiation from adolescent folliculosis can usually be made by recognition of the normal skin between the follicles in the adolescent disorder. Follicular hyperkeratosis is distinguished from perifolliculosis by the ring of capillary congestion which occurs about each follicle in scorbutic perifolliculosis.

- Hyperpigmentation, hands and face: Asymptomatic with no inflammatory component. The skin shows increased coloration due to deposition of pigments, seen most frequently on the dorsum of the hands and lower forearms, particularly when skin hygiene is poor. There is not the sharp line of demarcation at the border of the lesion such as one sees in pellagra. Also, not to be confused with sun tan. Any other abnormality of pigmentation should be noted and described under "Other."

- Dry or scaling skin (xerosis): Xerosis is a clinical term used to describe a dry and crinkled skin which is made more obvious by pushing the skin parallel to the surface. In more pronounced cases it is often mottled and pigmented and may appear as scaly or alligator-like pseudoplaques, usually not greater than 5 mm. in diameter. The nutritional significance of it is not established. Differential diagnosis must be made between this condition and changes due to dirt, exposure, and ichthyosis.

- Perifolliculosis: Congestion around the follicles which does not blanch upon pressure. (See discussion of follicular hyperkeratosis above.) There is an early ring of capillary engorgement around some hair follicles which does not disappear on pressure. It is more frequently encountered on the dependent parts such as the legs. Swelling and hypertrophy of the follicles may occur, at which time the skin becomes rough. Follicular hyperkeratosis may coexist. (This is indicated as perifolliculitis on the exam form.)

- Petechiae: Minute hemorrhages under the skin which do not blanch with pressure. Record petechiae which you as a physician judge to be due to abnormalities of the examinee. Do not record normal responses to minor trauma as positives. Qualify by describing distribution and severity.

- Mosaic skin: This is usually found on the lower legs and constitutes a dry, atrophic alteration of the skin with a mosaic-like pattern and a certain luster of the surface. It is associated with conditions where the superficial layers of the skin are subject to stretching (increased tension) due to underlying edema, e.g., in protein deficiency.

- Pellagrous dermatitis: Areas of dry dermatitis-like lesions on the dorsal surface of hands, cheeks, forehead, and if exposed, on the neck (Casals necklace).

- Ecchymoses: Small hemorrhage spots, larger than petechiae, in the skin or mucous membrane forming a nonelevated rounded or irregular, blue or purplish patch. Report ecchymoses which you as a physician judge to be due to abnormalities of the examinee. Do not report normal responses to known minor trauma.

- Spider Angioma: A tumor whose cells tend to form blood vessels looking like a spider which blanch with pressure.

- Eczema: A superficial inflammatory process involving primarily the epidermis, characterized early by redness, itching, minute papules and vessels, weeping, oozing and crusting, and later by scaling.

- Inflammation: A localized response elicited by injury or destruction of tissues characterized by pain, heat, redness, swelling and loss of function.

- Impetigo: A streptococcal infection of the skin characterized by fragile, grouped, pinhead-sized vesicles or pustules that become confluent and rupture early, forming rapidly enlarging and spreading erosions with bright yellow crusts that are attached in the center and have elevated margins.

- Scars: Report only scars that are the result of trauma, infection or other similar abnormality. Do not include surgical scars of the face and scalp, extremities, chest, abdomen, etc. These should have been reported in the appropriate section of the examination.

- Urticaria: A vascular reaction (hives) of the skin marked by the transient appearance of smooth, slightly elevated patches or wheals which are redder or paler than the surrounding skin and often attended by severe itching.

- Infestation: Parasitic attack of the skin by insects or parasitic invasion of the tissues, for example, by helminths.

- Describe other abnormalities of skin under "Other." Also describe listed conditions found in greater detail by extent, size, severity, location, etc.

1.20 Pulse and Blood Pressure Measurement

Repeat the pulse and blood pressure measurements using the procedures in Section 1.10. Measure and record only the pulse for examinees less than six years old.

1.21 Back

1.21.1 Procedure

With examinee standing:

- Inspect spinal profile, observing normal concave cervical, convex thoracic, and concave lumbar curves.
- Inspect spine for lateral curvature.
- Palpate spinous processes, sciatic notch and sacroiliac area for tenderness and spasm.
- Test range of motion of lower spine by:
  - Asking examinee to bend knees slightly and touch toes. Note symmetry and ease of movement.
  - While stabilizing the examinee's pelvis with your hands have the examinee bend sideways and backwards and twist trunk.
  - Have examinee flex chin to chest, and then to extend head backward. Note: Do last part of this test cautiously if examinee is over 55 years old.

1.21.2 Recording of Findings and Definitions

- Scoliosis - Lateral curvature of the spine. Usually consists of two curves, the original one and a compensatory curve in the opposite direction.
- Kyphosis - Exaggeration or angulation of normal posterior curve of spine or excessive curvature of the spine with convexity backward.
- Lordosis - Abnormal anterior convexity of the spine.
- Record abnormal findings by checking "Yes" boxes as appropriate. Check "No" box if no abnormality is found.

1.22 Gait

1.22.1 Procedure

- Assess examinee's gait as he/she enters the room and during the entire examination. Gait should be relaxed with easy alternate arm swing. Face and head should lead rest of body on turns.
- Examine lower extremities for evidence of bowed legs, knock knees, and varicose veins.

1.22.2 Recording of Findings and Definitions

- If examinee shows abnormality of gait such as staggering, limping, dragging one foot, shuffling, etc., check "Not normal" box.
- Bowed legs (genu varum) - Bilateral concave deformities of the thighs and tibiae should be recorded, even if mild.
- Knock knees (genu valgum) - Bilateral convex deformities of the knees and tibiae should be noted only if marked.
- Varicose veins - Enlarged twisted veins of the lower legs. If present, record severity by checking the appropriate box for the affected leg(s):
  - Severe -- Varicosities with ulcerations, discolorations, swelling and edema.
  - Moderate -- Varicosities with discoloration and possibly swelling but no ulcerations.
  - Mild -- Simple varicosities with no other complication.
  - None -- No varicosities.
- If no problems are evidenced, check "Normal" box.

1.23 Health Status

1.23.1 Procedure

This is the examining physician's subjective impression of the health status of the examinee.

1.23.2 Recording of Findings and Results

On the basis of your examination and observation indicate your subjective opinion of the examinee's health status. Is it "excellent," "very good," "good," "fair," or "poor?" Check the box corresponding to your opinion.

1.24 Nutritional Status

1.24.1 Procedure

This is the examining physician's subjective impression of the nutritional status of the examinee.

1.24.2 Recording of Findings and Results

Indicate your subjective opinion regarding your judgment of the examinee's nutritional status. Is it "Normal nutrition," or "Abnormal nutrition?" Check the box that indicates your judgment.

1.25 Weight Status

1.25.1 Procedure

This is the examining physician's subjective impression of the weight status of the examinee.

1.25.2 Recording of Findings and Results

Indicate your subjective opinion regarding your judgment of the examinee's weight status. Is it "Obesity," "Normal weight," or "Underweight?" Check the box that indicates your judgment.

1.26 Diagnostic Impressions and Health Care Needs

1.26.1 Procedure

The purpose of this page of the exam form is to identify the health status of the examinee. Current disorders, whether now receiving care or not, which require continuing physician care are to be noted and characterized. Based on the limited information that is available to the physician from the review of the Sample Person Questionnaire and the physical exam, give your impression of health care needs for conditions that appear to have any of the following characteristics:

- Potentially or presently life threatening, or
- Causing loss of functioning; or limitation of activity for the previous three months or longer, or
- On a potentially downward course.

As stated in Section 1.3 of this appendix, the second objective of the physician's examination is to list the conditions found on examination. The conditions to be coded include only those the physician finds from the history or examination. Do not code or list any condition that you learn about from other MEC staff members. The conditions that you code are to be characterized according to the type of condition, the basis for the judgment of the condition, the confidence in this determination, the severity of the condition, and whether or not a physician has been consulted about this condition. Central to this characterization is the assigning of ICD codes to the identified condition.

ICD coding is important because it provides numerical abbreviations for the major conditions observed. These codes facilitate computer analysis of the conditions which will then be compiled and be compared to previous NHANES data. You will be looking up a condition you discover in the exam, finding the correct ICD code and entering it in the space provided.

Only conditions which are either life threatening, or disabling, or are on a downward course should be listed and coded. Therefore, conditions such as transient upper respiratory infections, allergic rhinitis, and other minor or corrected conditions are not to be coded or listed, since they do not fit the criteria described above.

The International Classification of Diseases (ICD) 1975 revision is in two volumes. These manuals contain listings of conditions along with the four digit ICD code. They are described below.

Volume I: Tabular List

Volume I, the Tabular List, should be regarded as the primary coding tool. It is arranged in 17 main sections which deal first with diseases caused by well-defined infective agents; these are followed by category sections for neoplasms, and endocrine, metabolic, and nutritional diseases. Most of the remaining diseases are arranged according to their principal anatomical site, with special sections for mental diseases, complications of pregnancy and childbirth, certain diseases originating in the perinatal period, and ill-defined conditions including symptoms and a chapter of injuries or trauma. The 17 chapters are further divided into sections, categories and subcategories.

The titles of these chapters are as follows:

I. Infectious and Parasitic Diseases
II. Neoplasms
III. Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders
IV. Diseases of the Blood and Blood-forming Organs
V. Mental Disorders
VI. Diseases of the Nervous System and Sense Organs
VII. Diseases of the Circulatory System
VIII. Diseases of the Respiratory System
IX. Diseases of the Digestive System
X. Diseases of the Genitourinary System
XI. Complications of Pregnancy, Childbirth, and the Puerperium
XII. Diseases of the Skin and Subcutaneous Tissue
XIII. Diseases of the Musculoskeletal System and Connective Tissue
XIV. Congenital Anomalies
XV. Certain Conditions originating in the Perinatal Period
XVI. Symptoms, Signs and Ill-defined Conditions
XVII. Injury and Poisoning

The Tabular List also contains the Supplementary Classification of External Causes of Injury and Poisoning (E Code) which is used in preference to a code from Chapter XVII in classifying the underlying cause of death.

The ICD-9 Tabular List (Volume I) for the Disease and Nature of Injury Classification makes use of certain abbreviations, punctuation, symbols, and other conventions which need to be clearly understood.

Abbreviations

NOS — Not otherwise specified. This abbreviation is the equivalent of "unspecified."

Punctuation

Brackets are used to enclose synonyms, alternative wordings, or explanatory phrases.

() — Parentheses are used to enclose supplementary words which may be present or absent in the statement of a disease without affecting the code number to which it is assigned. They are also used to enclose numeric codes in the inclusion and exclusion notes and at the end of certain terms.

: — Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers which follow in order to make it assignable to a given category.

Braces are used to enclose a series of terms, each of which is modified by the statement appearing at the right of the brace.

Symbols

Daggers are used to indicate categories or subcategories for underlying cause of death use when the categories are subject to dual classification.

* — Asterisks are used to indicate categories and subcategories for morbidity or hospital use when the categories are subject to dual classification.

Notations

Includes: This note is used to further define or give examples of the content of material. This note sometimes appears under the chapter title, but most frequently appears under the section title or the category title.

Excludes: This note is used to indicate terms which are classified elsewhere. It appears under chapter titles, section titles, category titles, and also under subcategories within the classification.

Volume II: Alphabetic Index

This volume is the Alphabetic Index to Volume I, Diseases: Tabular List, of the International Classification of Diseases, 9th Revision.

The Alphabetic Index is an important supplement to the Tabular List since it contains many diagnostic terms which do not appear in Volume I. Terms listed in the categories of the Tabular List are not meant to be exhaustive; they serve as examples of the content of the category. The Index, however, includes most diagnostic terms currently in use.

Arrangement

The Alphabetic Index is divided into three sections:

o Section I, Index to Diseases and Injuries:

This section contains terms referring to diseases (categories 001-799), and injuries (categories 800-999, except for poisonings by drugs and chemicals), see pages 3-532.

o Section II, Alphabetic Index to External Causes of Injury (E Code):

This section is not used for HHANES. It contains external causes responsible for death. These terms are not medical terms, but usually terms which describe the circumstances under which an accident or an act of violence occurred. External causes include accidents, homicide, suicide, therapeutic misadventures as well as deaths due to operations of war.

o Section III, Table of Drugs and Chemicals:

This table gives the code numbers for drugs, medications, and other chemical substances as the cause of poisoning. This section is not used for HHANES.

Conventions

Many of the conventions used in the Tabular List (Volume I) are also used in the Index (Volume 2).

NEC Not elsewhere classifiable. The category number for the term including NEC is to be used only when the coder lacks the information necessary to code the term to a more specific category.

() Parentheses are used to enclose supplementary words which may be present or absent in the statement of a disease without affecting the code number to which it is assigned. They are also used to enclose numeric codes in the inclusion and exclusion notes and at the end of certain terms.

†* Daggers and asterisks are used to indicate categories or subcategories subject to dual classification. The dagger (†) indicates etiology and the asterisk (*) indicates manifestation.

#/ These symbols direct the coder to special notes and instructions for coding neoplasms.

As stated above, Volume I, the Tabular List, should be regarded as the primary coding tool. Volume II, the Alphabetical Index, is used simply as a means to direct the user to the appropriate category in Volume I. Reference should always be made back to Volume I to ensure that the code given by the Index fits the circumstances of a particular case.

The Index is organized in the form of lead terms, which start at the extreme left column, and show various levels of indentation, progressing further and further to the right. A complete index term, therefore, may be comprised of several lines, sometimes quite widely separated.

The lead term is usually the name of a disease or pathological condition. The terms indented underneath are either varieties of the condition, or anatomical sites affected.

EXAMPLES: Congenital myocardial insufficiency is indexed:

Insufficiency
  myocardial
    congenital 746.8

Senile brain disease is indexed:

Disease
  brain
    senile 331.2

Acute appendicitis is indexed:

Appendicitis
  acute 540.9

The index includes many cross-references. Cross-referencing by synonyms, closely related terms and code categories begin with "see" and "see also." "See" is an explicit direction to look elsewhere for the code assignment. "See also" directs the coder elsewhere if all the information is not listed under the main entry. Reference may be to another entry in the Index or to a category in Volume I.

EXAMPLES: Paralysis, paralytic
- cerebral
-- spastic infantile - see Palsy, cerebral

It is necessary to refer to Cerebral palsy for the code. Other modifiers may be found indented under "Cerebral palsy."

Addiction
- drug - (see also Dependence) 304.9

The Index indicates that if the only condition on the report is "drug addiction," the code is 304.9, but if any other information is present, such as a specified drug, the term "Dependence" should be looked up.

Enlargement, enlarged - see also Hypertrophy
- adenoids (and tonsils) 474.1
- alveolar ridge 525.8 etc.

If the coder does not find the site of the enlargement among the indents beneath "Enlargement," he should look among the indents beneath "Hypertrophy" where a more complete list of sites is given.

Anatomical sites and very general adjectival modifiers are not normally used as lead terms in the Index. Anatomical sites and some modifiers are listed with the note "see condition." This instructs the coder to look for the condition or disease (lead term) in the Index.

The Introduction of the Index contains more detailed explanations about the use of the Index, its general arrangements and conventions used.

Steps for ICD Coding

The following steps should be followed for ICD coding:

1. While the examinee is present write a complete description of the condition under item a. Complete the information requested for items b-e as explained.

2. After the examinee has left the room, locate the main term for the listed condition in the Alphabetic Index (Volume II).

3. Refer to any notes under the main term.

4. Refer to any modifiers of the main term.

5. Refer to any subterms indented under the main term.

6. Follow any cross-reference instructions.

7. Verify the code number in the Tabular List (Volume I).

8. Read and obtain guidance from any instructional terms in the Tabular List.

9. Assign the code thus obtained.

10. Write in the code using three digits or four digits as listed, with a decimal point after the third digit, if appropriate. Check to make sure these entries are legible.

For quality control purposes, a percentage of the codes will be checked by NCHS and by Westat. You will receive feedback on your coding based on the quality control checks.

What Conditions to Code

Code all conditions that fall into any one of the following categories:

- Potentially or presently life threatening, or
- Causing loss of functioning or limitation of activity for the previous three months or longer, or
- On a potential downward course.

Conditions included in these criteria are controlled and uncontrolled hypertension, controlled and uncontrolled diabetes, cancer that has been treated within the past five years, crippling arthritis, severe asthma, and similar other conditions.

Conditions which are excluded are successful heart valve implant, corrected cleft palate, minor deformities such as flat feet, fallen arches, minor arthritis, colds, hay fever and other similar trivial conditions.

1.26.2 Recording of Findings and Results

- Conditions: Write the name of the suspected condition which requires health care. Diagnostic impressions may be on the basis of the physical exam and/or the history (S.P.Q.). Not all findings should be listed, only those deemed significant in relation to the criteria detailed in Section 1.25.1

- If no conditions are presented that are included in the criteria, check the box next to "None" and go to the next page of the examination form.

- Basis for Judgment: Mark the appropriate box according to whether the condition is determined from the Adult or Child Sample Person Questionnaire, physician's exam or both.

- Confidence in Assessment: Indicate the certainty of each condition as to whether it is certain, likely, or uncertain.

- Severity of Condition: For each listing, indicate the seeming severity of each, checking whether it appears to be mild, moderate, or severe. This will be strictly subjective and based on your own appraisal. Should there arise some difficulty in deciding between two of the possible classifications, the lesser should be selected.

All conditions listed are not to be considered severe despite the criteria listed earlier (the criteria do not include severity). For example, an examinee with a blood pressure of 132/92 should be listed as having hypertension with the severity coded as "Mild." If an examinee with the same reading as above has a history of hypertension, is taking medication, and has seen a physician recently, the severity code would depend on the types and dose(s) of medication(s). A third example of a hypertensive examinee is one whose blood pressure is 148/96. For this examinee the condition should be coded as "Severe."

For a diabetic examinee who does not take any insulin but who controls the condition with diet, the condition would be coded as "Mild." For a diabetic who is insulin dependent and who has physiological changes due to the diabetes, the code would be "Severe."

- Has A Physician Been Consulted Regarding This Condition Within the Last Year?

  -- If it is known from the medical history that the examinee has seen a physician about a particular condition do not ask this question but check "Yes."

  -- If it is not clear from the medical history that a physician has been seen for the particular condition. It is important that any existing physician/patient rapport not be disrupted. Also, this information may be sensitive in cases where a condition exists and the physician and/or the family have decided not to reveal the diagnosis to the examinee. In these cases we have established a procedure that will, we hope, screen the intent of the question from the examinee. To the examinee say, "I'm interested in getting some information about several health conditions. Please tell me if a doctor has ever said you have: (1) cataracts?, (2) diabetes?, (3) arthritis?, (4) (insert the particular condition in question)?". If the examinee has one or more of these mock conditions substitute other mock conditions. Be sure to add some mock conditions in addition to asking about the true conditions.

- o ICD code for condition:

  Each condition should be coded according to the Ninth Revision of the International Classification of Diseases, (ICD). These numeric codes will be used to facilitate computer analysis of the conditions. Use the two ICD unabbreviated volumes to locate the condition. Enter the code on the form.

- o Make sure that the conditions listed are legible and do not use medical shorthand.

- o This section of the Physician's Exam Form contains space for five conditions to be identified. Additional copies of this page will be available for use when an examinee has more than five conditions.

- o The physician also must ICD code any dental conditions which meet any of the three criteria (life threatening, or limitation of activity for three months or longer, or on a potentially downward course). Ask the dentist at the end of each exam session if any examinees had any such conditions.

1.27 Substantiating Comments on Diagnostic Impressions and Health Care Needs

1.27.1 Procedure

In this section the physician should write in the Level of Referral for this examinee along with any additional comments about conditions s/he found or changes in medical care s/he would recommend if the examinee were her/his patient. This would include all the abnormalities found or additional diagnoses and treatment. The condition outlined need not be one in which a diagnosis is already available, but may be a collection of symptoms, signs, etc.

The levels of referral are:

Level I - emergency;
Level II - needs medical care within one month;
Level III - no major medical findings.

Also on this page the dentist will record oral soft tissue pathology if it is found during the dental exam and Level II vision referrals. The dentist will record after all the exams for the session are completed.

1.27.2 Recording of Findings and Definitions

There are three types of information the physician records on this page. They are:

- o The Level of Referral (I, II, or III) for this examinee, check the appropriate box,

- o Any substantiating comments which relate to the conditions found during the examination,

- o Any important additional questions that were asked of the examinee, the answers to which were used to determine the diagnosis of the condition.

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