

B. LIMITATION OF ACTIVITIES PAGE

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

B. LIMITATION OF ACTIVITIES PAGE, Continued

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

FORM HHS-1 (784) 18-9-82

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

FORM HSA-1 (1988) (8-9-88)

D. RESTRICTED ACTIVITY PAGE PERSON 1		D2
Hand calendar. (The next questions refer to the 2 weeks outlined in red on that calendar, beginning Monday, (date) and ending this past Sunday (date).)		Refer to 2b and 3b. No days in 2b or 3b (6) 1 or more days in 2b or 3b (5)
D1	Refer to age. 1 Under 5 (4) 2 5-17 (3) 3 18 and over (1)	5. On how many of the (number in 2b or 3b) days missed from [work/school] did -- stay in bed more than half of the day because of illness or injury? oo None _____ No. of days
1a. DURING THOSE 2 WEEKS, did -- work at any time at a job or business, not counting work around the house? (Include unpaid work in the family [farm/business].) 1 Yes (Mark "Wa" box, THEN 2) 2 No		Refer to 2b, 3b, and 4b. 6a. (Not counting the day(s) [missed from work missed from school (and) in bed]), Was there any (OTHER) time during those 2 weeks that -- cut down on the things -- usually does because of illness or injury? Yes oo No (D3)
b. Even though -- did not work during those 2 weeks, did -- have a job or business? 1 Yes (Mark "Wb" box, THEN 2) 2 No (4)		b. (Again, not counting the day(s) [missed from work missed from school (and) in bed]), During that period, how many (OTHER) days did -- cut down for more than half of the day because of illness or injury? oo None _____ No. of cut-down days
2a. During those 2 weeks, did -- miss any time from a job or business because of illness or injury? 1 Yes oo No (4)		D3 Refer to 2-6. No days in 2-6 (Mark "No" in RD, THEN NP) 1 or more days in 2-6 (Mark "Yes" in RD, THEN 7)
b. During that 2-week period, how many days did -- miss more than half of the day from -- job or business because of illness or injury? oo None (4) _____ No. of work-loss days (4)		Refer to 2b, 3b, 4b, and 6b. 7a. What (other) condition caused -- to [miss work miss school (or) stay in bed (or) cut down] during those 2 weeks? (Enter condition in C2, THEN 7b)
3a. During those 2 weeks, did -- miss any time from school because of illness or injury? 1 Yes oo No (4)		b. Did any other condition cause -- to [miss work miss school (or) stay in bed (or) cut down] during that period? 1 Yes (Reask 7a and b) 2 No
b. During that 2-week period, how many days did -- miss more than half of the day from school because of illness or injury? oo None (4) _____ No. of school-loss days		FOOTNOTES
4a. During those 2 weeks, did -- stay in bed because of illness or injury? 1 Yes oo No (6)		
b. During that 2-week period, how many days did -- stay in bed more than half of the day because of illness or injury? oo None (6) _____ No. of bed days (D2)		

FORM HIS-1 (1984) (8-9-83)

E. 2-WEEK DOCTOR VISITS PROBE PAGE

Read to respondent(s):
 These next questions are about health care received during the 2 weeks outlined in red on that calendar.

E1

Refer to age.

E1

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

- 1a. During those 2 weeks, how many times did -- see or talk to a medical doctor? (Include all types of doctors, such as dermatologists, psychiatrists, and ophthalmologists, as well as general practitioners and osteopaths.) (Do not count times while an overnight patient in a hospital.)
-
- b. During those 2 weeks, how many times did anyone see or talk to a medical doctor about --? (Do not count times while an overnight patient in a hospital.)

- 1a. and b. None } (NP)
 Number of times

2a. (Besides the time(s) you just told me about) During those 2 weeks, did anyone in the family receive health care at home or go to a doctor's office, clinic, hospital or some other place? Include care from a nurse or anyone working with or for a medical doctor. Do not count times while an overnight patient in a hospital.

Yes No (3a)

b. Who received this care? Mark "DR Visit" box in person's column.

2b. DR Visit

c. Anyone else? Yes (Reask 2b and c) No

Ask for each person with "DR Visit" in 2b:

d. How many times did -- receive this care during that period?

d.
 Number of times

3a. (Besides the time(s) you already told me about) During those 2 weeks, did anyone in the family get any medical advice, prescriptions or test results over the PHONE from a doctor, nurse, or anyone working with or for a medical doctor?

Yes No (E2)

b. Who was the phone call about? Mark "Phone call" box in person's column.

3b. Phone call

c. Were there any calls about anyone else? Yes (Reask 3b and c) No

Ask for each person with "Phone call" in 3b:

d. How many telephone calls were made about --?

d.
 Number of calls

E2

Add numbers in 1, 2d, and 3d for each person. Record total number of visits and calls in "2-WK, DV" box in item C1.

FOOTNOTES

F. 2-WEEK DOCTOR VISITS PAGE

DR VISIT 1

Refer to CI, "2-WK, DV" box.		PERSON NUMBER _____	
F1	Refer to age.	F1	<input type="checkbox"/> Under 14 (1b) <input type="checkbox"/> 14 and over (1a)
1a.	On what (other) date(s) during those 2 weeks did -- see or talk to a medical doctor, nurse, or doctor's assistant?	1a. and b.	Month _____ Date _____ OR <input type="checkbox"/> 7777 Last week <input type="checkbox"/> 8888 Week before
b.	On what (other) date(s) during those 2 weeks did anyone see or talk to a medical doctor, nurse, or doctor's assistant about --?	c.	1 <input type="checkbox"/> Yes (Reask 1a or b and c) 2 <input type="checkbox"/> No (Ask 2-5 for each visit)
c.	Were there any other visits or calls for -- during that period? Make necessary correction to 2-WK, DV box in CI.	2.	01 <input type="checkbox"/> Telephone Not in hospital: 02 <input type="checkbox"/> Home 03 <input type="checkbox"/> Doctor's office 04 <input type="checkbox"/> Co. or ind. clinic 05 <input type="checkbox"/> Other clinic 06 <input type="checkbox"/> Lab 07 <input type="checkbox"/> Other (Specify) _____ Hospital: 08 <input type="checkbox"/> O.P. clinic 09 <input type="checkbox"/> Emergency room 10 <input type="checkbox"/> Doctor's office 11 <input type="checkbox"/> Lab 12 <input type="checkbox"/> Overnight patient (Next DR visit) 13 <input type="checkbox"/> Other (Specify) _____
2.	Where did -- receive health care on (date in 1), at a doctor's office, clinic, hospital, some other place, or was this a telephone call? If doctor's office: Was this office in a hospital? If hospital: Was it the outpatient clinic or the emergency room? If clinic: Was it a hospital outpatient clinic, a company clinic, a public health clinic, or some other kind of clinic? If lab: Was this lab in a hospital? What was done during this visit? (Footnote)	3a. and b.	1 <input type="checkbox"/> Yes (3f) 8 <input type="checkbox"/> DK if M.D. (3c) 2 <input type="checkbox"/> No (3c) 9 <input type="checkbox"/> DK who was seen (3f)
3a.	Ask 3b if under 14. Did -- actually talk to a medical doctor?	c.	Type _____ 99 <input type="checkbox"/> DK
b.	Did anyone actually talk to a medical doctor about --?	d.	1 <input type="checkbox"/> One (3f) 3 <input type="checkbox"/> None (4) 2 <input type="checkbox"/> More 9 <input type="checkbox"/> DK
c.	What type of medical person or assistant was talked to?	e. and f.	1 <input type="checkbox"/> GP (4) 2 <input type="checkbox"/> Specialist (3g) 9 <input type="checkbox"/> DK (4)
d.	Does the (entry in 3c) work with or for ONE doctor or MORE than one doctor?	g.	Kind of specialist _____
e.	For this (visit/call) what kind of doctor was the (entry in 3c) working with or for - a general practitioner or a specialist?	4a. and b.	1 <input type="checkbox"/> Condition (Item C2, THEN 4g) 2 <input type="checkbox"/> Pregnancy (4e) 3 <input type="checkbox"/> Test(s) or examination (4c) 4 <input type="checkbox"/> Other (Specify) _____ (4g)
f.	Is that doctor a general practitioner or a specialist?	c.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No
g.	What kind of specialist?	d.	<input type="checkbox"/> Yes (4h) <input type="checkbox"/> No (4g)
4a.	Ask 4b if under 14. For what condition did -- see or talk to the [doctor/(entry in 3c)] on (date in 1)? Mark first appropriate box.	e.	<input type="checkbox"/> Yes <input type="checkbox"/> No (4g)
b.	For what condition did anyone see or talk to the [doctor/(entry in 3c)] about -- on (date in 1)? Mark first appropriate box.	f.	Condition _____ (Item C2, THEN 4g)
c.	Was a condition found as a result of the [test(s)/examination]?	g.	<input type="checkbox"/> Yes <input type="checkbox"/> No (5)
d.	Was this [test/examination] because of a specific condition -- had?	h.	<input type="checkbox"/> Pregnancy (4e) _____ Condition _____ (Item C2, THEN 4g)
e.	During the past 2 weeks was -- sick because of -- pregnancy?	5a.	0 <input type="checkbox"/> Telephone in 2 (Next DR visit) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next DR visit)
f.	What was the matter?	b.	(1) _____ (2) _____
g.	During this [visit/call] was the [doctor/(entry in 3c)] talked to about any (other) condition?	c.	<input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No
h.	What was the condition?		
5a.	Mark box if "Telephone" in 2. Did -- have any kind of surgery or operation during this visit, including bone settings and stitches?		
b.	What was the name of the surgery or operation? If name of operation not known, describe what was done.		
c.	Was there any other surgery or operation during this visit?		

H. CONDITION LISTS 1 AND 2

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

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

1		2	
<p>1a. Does anyone in the family (read names) NOW have – If "Yes," ask 1b and c. b. Who is this? c. Does anyone else NOW have – Enter condition and letter in appropriate person's column.</p>		<p>2a. Does anyone in the family (read names) NOW have – If "Yes," ask 2b and c. b. Who is this? c. Does anyone else NOW have – Enter condition and letter in appropriate person's column.</p>	
<p>A. PERMANENT stiffness or any deformity of the foot, leg, fingers, arm, or back? (Permanent stiffness – joints will not move at all.)</p>		<p>A–L are conditions affecting Hearing Vision Speech</p>	
<p>B. Paralysis of any kind?</p>		<p>M-AA are impairments.</p>	
<p>1d. DURING THE PAST 12 MONTHS, did anyone in the family have – If "Yes," ask 1e and f. e. Who was this? f. DURING THE PAST 12 MONTHS, did anyone else have – Enter condition and letter in appropriate person's column. C–L are conditions affecting the bone and muscle. M–W are conditions affecting the skin.</p>		<p>Reask 2a</p>	
C. Arthritis of any kind or rheumatism?	Reask 1d	A. Deafness in one or both ears?	D. A missing joint?
D. Gout?	M. A tumor, cyst, or growth of the skin?	B. Any other trouble hearing with one or both ears?	P. A missing breast, kidney, or lung?
E. Lumbago?	N. Skin cancer?	C. Tinnitus or ringing in the ears?	Q. Palsy or cerebral palsy? (ser'ə-brəl)
F. Sciatica?	O. Eczema or psoriasis? (ek'sə-mə) or (sə-rye-uh-sis)	D. Blindness in one or both eyes?	R. Paralysis of any kind?
G. A bone cyst or bone spur?	P. TROUBLE with dry or itching skin?	E. Cataracts?	S. Curvature of the spine?
H. Any other disease of the bone or cartilage?	Q. TROUBLE with acne?	F. Glaucoma?	T. REPEATED trouble with neck, back, or spine?
I. A slipped or ruptured disc?	R. A skin ulcer?	G. Color blindness?	U. Any TROUBLE with fallen arches or flatfeet?
J. REPEATED trouble with neck, back, or spine?	S. Any kind of skin allergy?	H. A detached retina or any other condition of the retina?	V. A clubfoot?
K. Bursitis?	T. Dermatitis or any other skin trouble?	I. Any other trouble seeing with one or both eyes EVEN when wearing glasses?	W. A trick knee?
L. Any disease of the muscles or tendons?	U. TROUBLE with ingrown toenails or fingernails?	J. A cleft palate or harelip?	X. PERMANENT stiffness or any deformity of the foot, leg, or back? (Permanent stiffness – joints will not move at all.)
	V. TROUBLE with bunions, corns, or calluses?	K. Stammering or stuttering?	Y. PERMANENT stiffness or any deformity of the fingers, hand, or arm?
	W. Any disease of the hair or scalp?	L. Any other speech defect?	Z. Mental retardation?
		M. Loss of taste or smell which has lasted 3 months or more?	AA. Any condition caused by an accident or injury which happened more than 3 months ago? If "Yes," ask: What is the condition?
		N. A missing finger, hand, or arm; toe, foot, or leg?	

FORM HIS-1 (1984) 18-9-631

H. CONDITION LISTS 3 AND 4

Read to respondent(s) and ask list specified in A2:
Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

3

- 3a. DURING THE PAST 12 MONTHS, did anyone in the family (read names) have -
If "Yes," ask 3b and c.
- b. Who was this?
- c. DURING THE PAST 12 MONTHS, did anyone else have -
Enter condition and letter in appropriate person's column.
Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list.
Conditions affecting the digestive system.

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

4

- 4a. DURING THE PAST 12 MONTHS, did anyone in the family (read names) have -
If "Yes," ask 4b and c.
- b. Who was this?
- c. DURING THE PAST 12 MONTHS, did anyone else have -
Enter condition and letter in appropriate person's column.
A-B are conditions affecting the glandular system
C is a blood condition
D-I are conditions affecting the nervous system
J-Y are conditions affecting the genito-urinary system

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

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

H. CONDITION LISTS 5 AND 6

Read to respondent(s) and ask list specified in A2.
Now I am going to read a list of medical conditions. Tell me if anyone in the family has had any of these conditions, even if you have mentioned them before.

<p>5</p> <p>5a. Has anyone in the family (<i>read names</i>) EVER had – If "Yes," ask 5b and c.</p> <p>b. Who was this? –</p> <p>c. Has anyone else EVER had – Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%; padding: 2px;">A. Rheumatic fever?</td> <td style="width: 50%; padding: 2px;">G. A stroke or a cerebrovascular accident? (ser'a-bro vas ku-lar)</td> </tr> <tr> <td style="padding: 2px;">B. Rheumatic heart disease?</td> <td style="padding: 2px;">H. A hemorrhage of the brain?</td> </tr> <tr> <td style="padding: 2px;">C. Hardening of the arteries or arteriosclerosis?</td> <td style="padding: 2px;">I. Angina pectoris? (pek'to-ris)</td> </tr> <tr> <td style="padding: 2px;">D. Congenital heart disease?</td> <td style="padding: 2px;">J. A myocardial infarction?</td> </tr> <tr> <td style="padding: 2px;">E. Coronary heart disease?</td> <td style="padding: 2px;">K. Any other heart attack?</td> </tr> </table> <p>5d. DURING THE PAST 12 MONTHS, did anyone in the family have – If "Yes," ask 5e and f.</p> <p>e. Who was this?</p> <p>f. DURING THE PAST 12 MONTHS, did anyone else have – Enter condition and letter in appropriate person's column. Conditions affecting the heart and circulatory system.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%; padding: 2px;">L. Damaged heart valves?</td> <td style="width: 50%; padding: 2px;">Q. Any blood clots?</td> </tr> <tr> <td style="padding: 2px;">M. Tachycardia or rapid heart?</td> <td style="padding: 2px;">R. Varicose veins?</td> </tr> <tr> <td style="padding: 2px;">N. A heart murmur?</td> <td style="padding: 2px;">S. Hemorrhoids or piles?</td> </tr> <tr> <td style="padding: 2px;">O. Any other heart trouble?</td> <td style="padding: 2px;">T. 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DURING THE PAST 12 MONTHS, did anyone else have – Enter condition and letter in appropriate person's column. Make no entry in item C2 for cold; flu; red, sore, or strep throat; or "virus" even if reported in this list. Conditions affecting the respiratory system.</p> <p style="text-align: center; margin-left: 40px;">Reask 6a.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 50%; padding: 2px;">A. Bronchitis?</td> <td style="width: 50%; padding: 2px;">K. A missing lung?</td> </tr> <tr> <td style="padding: 2px;">B. Asthma?</td> <td style="padding: 2px;">L. Lung cancer?</td> </tr> <tr> <td style="padding: 2px;">C. Hay fever?</td> <td style="padding: 2px;">M. Emphysema?</td> </tr> <tr> <td style="padding: 2px;">D. Sinus trouble?</td> <td style="padding: 2px;">N. Pleurisy?</td> </tr> <tr> <td style="padding: 2px;">E. A nasal polyp?</td> <td style="padding: 2px;">O. Tuberculosis?</td> </tr> <tr> <td style="padding: 2px;">F. 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If only 1 time, ask:</p> <p>2. How long did it last? If 1 month or longer, enter in item C2. If less than 1 month, do not record. If tonsils or adenoids were removed during past 12 months, enter the condition causing removal in item C2.</p>	A. Bronchitis?	K. A missing lung?	B. Asthma?	L. Lung cancer?	C. Hay fever?	M. Emphysema?	D. Sinus trouble?	N. Pleurisy?	E. A nasal polyp?	O. Tuberculosis?	F. A deflected or deviated nasal septum?	P. Any other work-related respiratory condition, such as dust on the lungs, silicosis, asbestosis, or pneu-mo-co-ni-o-sis?	G. * Tonsillitis or enlargement of the tonsils or adenoids?	Q. During the past 12 months did anyone (else) in the family have any other respiratory, lung, or pulmonary condition? If "Yes," ask: Who was this?—What was the condition? Enter in item C2, THEN reask Q.	H. * Laryngitis?	I. A tumor or growth of the throat, larynx, or trachea?	J. A tumor or growth of the bronchial tube or lung?	
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FORM HIS-1 (1984) 10-9-83

J. HOSPITAL PAGE		HOSPITAL STAY 1								
1. Refer to C1, "HOSP." box.		1. PERSON NUMBER _____								
2. You said earlier that -- was a patient in the hospital since (13-month hospital date) a year ago. On what date did -- enter the hospital ((the last time/the time before that))? Record each entry date in a separate Hospital Stay column.		Month	Date	Year 19 ____						
3. How many nights was -- in the hospital?		3. 0000 <input type="checkbox"/> None (Next HS) ____ Nights								
4. For what condition did -- enter the hospital? <ul style="list-style-type: none"> • For delivery ask: Was this a normal delivery? If "No," ask: What was the matter? • For newborn ask: Was the baby normal at birth? If "No," ask: What was the matter? • For initial "No condition" ask: Why did -- enter the hospital? • For tests, ask: What were the results of the tests? If no results, ask: Why were the tests performed? 		4. <table style="border: none;"> <tr> <td style="border: none;">1 <input type="checkbox"/> Normal delivery</td> <td rowspan="3" style="border: none; vertical-align: middle;">} (5)</td> </tr> <tr> <td style="border: none;">2 <input type="checkbox"/> Normal at birth</td> </tr> <tr> <td style="border: none;">3 <input type="checkbox"/> No condition</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Condition</td> <td style="border: none;"></td> </tr> </table>			1 <input type="checkbox"/> Normal delivery	} (5)	2 <input type="checkbox"/> Normal at birth	3 <input type="checkbox"/> No condition	<input type="checkbox"/> Condition	
1 <input type="checkbox"/> Normal delivery	} (5)									
2 <input type="checkbox"/> Normal at birth										
3 <input type="checkbox"/> No condition										
<input type="checkbox"/> Condition										
J1	Refer to questions 2, 3, and 2-week reference period.	J1 <table style="border: none;"> <tr> <td style="border: none;"><input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2. THEN 5)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> No nights in 2-week reference period (5)</td> </tr> </table>			<input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2. THEN 5)	<input type="checkbox"/> No nights in 2-week reference period (5)				
<input type="checkbox"/> At least one night in 2-week reference period (Enter condition in C2. THEN 5)										
<input type="checkbox"/> No nights in 2-week reference period (5)										
5a. Did -- have any kind of surgery or operation during this stay in the hospital, including bone settings and stitches?		5a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)								
b. What was the name of the surgery or operation? If name of operation not known, describe what was done.		b. (1) _____ (2) _____ (3) _____								
c. Was there any other surgery or operation during this stay?		c. <input type="checkbox"/> Yes (Reask 5b and c) <input type="checkbox"/> No								
6. What is the name and address of this hospital?		6. Name _____ Number and street _____ City or County _____ State _____								
FOOTNOTES										

FORM HIS-1 (1984) (8-9-83)

1. Name of condition _____

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

2. When did [---/anyone] last see or talk to a doctor or assistant about -- (condition)?
- | | |
|---|---|
| 0 <input type="checkbox"/> Interview week (Reask 2) | 5 <input type="checkbox"/> 2 yrs., less than 5 yrs. |
| 1 <input type="checkbox"/> 2-wk. ref. pd. | 6 <input type="checkbox"/> 5 yrs. or more |
| 2 <input type="checkbox"/> Over 2 weeks, less than 6 mos. | 7 <input type="checkbox"/> Dr. seen, DK when |
| 3 <input type="checkbox"/> 6 mos., less than 1 yr. | 8 <input type="checkbox"/> DK if Dr. seen |
| 4 <input type="checkbox"/> 1 yr., less than 2 yrs. | 9 <input type="checkbox"/> Dr. never seen |
- (3b)

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

- 1 Yes 2 No 3 DK

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

- b. What did he or she call it? _____ Specify
- | | |
|---|---|
| 1 <input type="checkbox"/> Color Blindness (NC) | 2 <input type="checkbox"/> Cancer (3e) |
| 3 <input type="checkbox"/> Normal pregnancy, normal delivery, vasectomy | 4 <input type="checkbox"/> Old age (NC) |
| 5 <input type="checkbox"/> Other (3c) | |

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

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

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

- 1 Yes (5) 2 No

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

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

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

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

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

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

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

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

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

Show the following detail:

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

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

- Infection Sore Soreness

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

Specify _____

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

- Tumor Cyst Growth

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

- 1 Malignant 2 Benign 3 DK

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

- | |
|---|
| 1 <input type="checkbox"/> 2-wk. ref. pd. |
| 2 <input type="checkbox"/> Over 2 weeks to 3 months |
| 3 <input type="checkbox"/> Over 3 months to 1 year |
| 4 <input type="checkbox"/> Over 1 year to 5 years |
| 5 <input type="checkbox"/> Over 5 years |
- b. When did -- (name of injury in 3b)?

Ask probes as necessary:
 (Was it on or since (first date of 2-week ref. period) or was it before that date?)
 (Was it less than 3 months or more than 3 months ago?)
 (Was it less than 1 year or more than 1 year ago?)
 (Was it less than 5 years or more than 5 years ago?)

K1	<p>Refer to RD and C2. <input type="checkbox"/> "Yes" in "RD" box AND more than 1 condition in C2 (6) <input type="checkbox"/> Other (K2)</p> <p>6a. During the 2 weeks outlined in red on that calendar, did -- (condition) cause -- to cut down on the things -- usually does? <input type="checkbox"/> Yes <input type="checkbox"/> No (K2)</p> <p>b. During that period, how many days did -- cut down for more than half of the day? 00 <input type="checkbox"/> None (K2) _____ Days</p> <p>7. During those 2 weeks, how many days did -- stay in bed for more than half of the day because of this condition? 00 <input type="checkbox"/> None _____ Days</p> <p>Ask if "Wa/Wb" box marked in C1: 8. During those 2 weeks, how many days did -- miss more than half of the day from -- job or business because of this condition? 00 <input type="checkbox"/> None _____ Days</p> <p>Ask if age 5-17: 9. During those 2 weeks, how many days did -- miss more than half of the day from school because of this condition? 00 <input type="checkbox"/> None _____ Days</p>																
K2	<p><input type="checkbox"/> Condition has "CL LTR" in C2 as source (10) <input type="checkbox"/> Condition does not have "CL LTR" in C2 as source (K4)</p> <p>10. About how many days since (12-month date) a year ago, has this condition kept -- in bed more than half of the day? (Include days while an overnight patient in a hospital.) 000 <input type="checkbox"/> None _____ Days</p> <p>11. Was -- ever hospitalized for -- (condition in 3)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																
K3	<p><input type="checkbox"/> Missing extremity or organ (K4) <input type="checkbox"/> Other (12)</p> <p>12a. Does -- still have this condition? 1 <input type="checkbox"/> Yes (K4) <input type="checkbox"/> No</p> <p>b. Is this condition completely cured or is it under control? 2 <input type="checkbox"/> Cured 3 <input type="checkbox"/> Under control (K4) 4 <input type="checkbox"/> Other (Specify) _____ (K4)</p> <p>c. About how long did -- have this condition before it was cured? <input type="checkbox"/> Less than 1 month OR Number _____ { <input type="checkbox"/> Months <input type="checkbox"/> Years</p> <p>d. Was this condition present at any time during the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																
K4	<p>0 <input type="checkbox"/> Not an accident/injury (NC) 1 <input type="checkbox"/> First accident/injury for this person (14) 8 <input type="checkbox"/> Other (13)</p>																
	<p>13. Is this (condition in 3b) the result of the same accident you already told me about? <input type="checkbox"/> Yes (Record condition page number where accident questions first completed.) → Page No. (NC) <input type="checkbox"/> No</p> <p>14. Where did the accident happen? 1 <input type="checkbox"/> At home (inside house) 2 <input type="checkbox"/> At home (adjacent premises) 3 <input type="checkbox"/> Street and highway (includes roadway and public sidewalk) 4 <input type="checkbox"/> Farm 5 <input type="checkbox"/> Industrial place (includes premises) 6 <input type="checkbox"/> School (includes premises) 7 <input type="checkbox"/> Place of recreation and sports, except at school 8 <input type="checkbox"/> Other (Specify) _____</p> <p>Mark box if under 18. <input type="checkbox"/> Under 18 (16)</p> <p>15a. Was -- under 18 when the accident happened? 1 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No</p> <p>b. Was -- in the Armed Forces when the accident happened? 2 <input type="checkbox"/> Yes (16) <input type="checkbox"/> No</p> <p>c. Was -- at work at -- job or business when the accident happened? 3 <input type="checkbox"/> Yes 4 <input type="checkbox"/> No</p> <p>16a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)</p> <p>b. Was more than one vehicle involved? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>c. Was [it/either one] moving at the time? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>17a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Part(s) of body *</th> <th style="width:50%;">Kind of injury</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table> <p>Ask if box 3, 4, or 5 marked in Q.5: b. What part of the body is affected now? How is -- (part of body) affected? Is -- affected in any other way?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Part(s) of body *</th> <th style="width:50%;">Present effects **</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table> <p>* Enter part of body in same detail as for 3g. ** If multiple present effects, enter in C2 each one that is not the same as 3b or C2 and complete a separate condition page for it.</p>	Part(s) of body *	Kind of injury							Part(s) of body *	Present effects **						
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FORM HIS-1 (1984) 18-9-83

L. DEMOGRAPHIC BACKGROUND PAGE

<p>L1</p>	<p>Refer to age.</p>	<p>L1</p> <p><input type="checkbox"/> Under 5 (NP) <input type="checkbox"/> 5-17 (2) <input type="checkbox"/> 18 and over (1)</p>																				
<p>1a. Did -- EVER serve on active duty in the Armed Forces of the United States?</p> <p>b. When did -- serve?</p> <p>Mark box in descending order of priority. Thus, if person served in Vietnam and in Korea, mark VN.</p> <table border="0"> <tr> <td>Vietnam Era (Aug. '64 to April '75)</td> <td>VN</td> </tr> <tr> <td>Korean War (June '50 to Jan. '55)</td> <td>KW</td> </tr> <tr> <td>World War II (Sept. '40 to July '47)</td> <td>WWII</td> </tr> <tr> <td>World War I (April '17 to Nov. '18)</td> <td>WWI</td> </tr> <tr> <td>Post Vietnam (May '75 to present)</td> <td>PVN</td> </tr> <tr> <td>Other Service (all other periods)</td> <td>OS</td> </tr> </table> <p>c. Was -- EVER an active member of a National Guard or military reserve unit?</p> <p>d. Was ALL of -- active duty service related to National Guard or military reserve training?</p>		Vietnam Era (Aug. '64 to April '75)	VN	Korean War (June '50 to Jan. '55)	KW	World War II (Sept. '40 to July '47)	WWII	World War I (April '17 to Nov. '18)	WWI	Post Vietnam (May '75 to present)	PVN	Other Service (all other periods)	OS	<p>1a.</p> <p>1 <input type="checkbox"/> Yes -- (Mark "AF" box, THEN 1b) 2 <input type="checkbox"/> No (2)</p> <p>b.</p> <table border="0"> <tr> <td>1 <input type="checkbox"/> VN</td> <td>5 <input type="checkbox"/> PVN</td> </tr> <tr> <td>2 <input type="checkbox"/> KW</td> <td>8 <input type="checkbox"/> OS</td> </tr> <tr> <td>3 <input type="checkbox"/> WWII</td> <td>9 <input type="checkbox"/> DK</td> </tr> <tr> <td>4 <input type="checkbox"/> WWI</td> <td></td> </tr> </table> <p>c.</p> <p><input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 7 <input type="checkbox"/> DK (2)</p> <p>d.</p> <p>1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	1 <input type="checkbox"/> VN	5 <input type="checkbox"/> PVN	2 <input type="checkbox"/> KW	8 <input type="checkbox"/> OS	3 <input type="checkbox"/> WWII	9 <input type="checkbox"/> DK	4 <input type="checkbox"/> WWI	
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4 <input type="checkbox"/> WWI																						
<p>2a. What is the highest grade or year of regular school -- has ever attended?</p> <p>b. Did -- finish the (number in 2a) [grade/year]?</p>		<p>2a.</p> <p>00 <input type="checkbox"/> Never attended or kindergarten (NP)</p> <p>Elem: 1 2 3 4 5 6 7 8 High: 9 10 11 12 College: 1 2 3 4 5 6 +</p> <p>b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>																				
<p><i>Hand Card R. Ask first alternative for first person; ask second alternative for other persons.</i></p> <p>3a. [What is the number of the group or groups which represents -- race?] [What is -- race?]</p> <p>Circle all that apply</p> <table border="0"> <tr> <td>1 - Aleut, Eskimo, or American Indian</td> <td>4 - White</td> </tr> <tr> <td>2 - Asian or Pacific Islander</td> <td>5 - Another group not listed - Specify</td> </tr> <tr> <td>3 - Black</td> <td></td> </tr> </table> <p>Ask if multiple entries:</p> <p>b. Which of those groups; that is, (entries in 3a) would you say BEST represents -- race?</p> <p>c. Mark observed race of respondent(s) only.</p>		1 - Aleut, Eskimo, or American Indian	4 - White	2 - Asian or Pacific Islander	5 - Another group not listed - Specify	3 - Black		<p>3a.</p> <p>1 2 3 4 5</p> <p>Specify</p> <p>b.</p> <p>1 2 3 4 5</p> <p>Specify</p> <p>c.</p> <p>1 <input type="checkbox"/> W 2 <input type="checkbox"/> B 3 <input type="checkbox"/> O</p>														
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2 - Asian or Pacific Islander	5 - Another group not listed - Specify																					
3 - Black																						
<p><i>Hand Card O.</i></p> <p>4a. Are any of those groups -- national origin or ancestry? (Where did -- ancestors come from?)</p> <p>b. Please give me the number of the group.</p> <p>Circle all that apply</p> <table border="0"> <tr> <td>1 - Puerto Rican</td> <td>5 - Chicano</td> </tr> <tr> <td>2 - Cuban</td> <td>6 - Other Latin American</td> </tr> <tr> <td>3 - Mexican/Mexicano</td> <td>7 - Other Spanish</td> </tr> <tr> <td>4 - Mexican American</td> <td></td> </tr> </table>		1 - Puerto Rican	5 - Chicano	2 - Cuban	6 - Other Latin American	3 - Mexican/Mexicano	7 - Other Spanish	4 - Mexican American		<p>4a.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <p>b.</p> <p>1 2 3 4 5 6 7</p>												
1 - Puerto Rican	5 - Chicano																					
2 - Cuban	6 - Other Latin American																					
3 - Mexican/Mexicano	7 - Other Spanish																					
4 - Mexican American																						

FORM HIS-1 (1984) (4-9-83)

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

<p>L2</p>	<p>Refer to "Age" and "Wa/Wb" boxes in C1.</p>	<p>L2</p> <p>0 <input type="checkbox"/> Under 18 (NP) 1 <input type="checkbox"/> Wa box marked (6a) 2 <input type="checkbox"/> Wb box marked (5a) 3 <input type="checkbox"/> Neither box marked (5b)</p>
<p>5a. Earlier you said that -- has a job or business but did not work last week or the week before. Was -- looking for work or on layoff from a job during those 2 weeks?</p>	<p>b. Earlier you said that -- didn't have a job or business last week or the week before. Was -- looking for work or on layoff from a job during those 2 weeks?</p>	<p>5a. 1 <input type="checkbox"/> Yes (5c) 2 <input type="checkbox"/> No (6b)</p> <p>b. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <p>c. 1 <input type="checkbox"/> Looking (6c) 3 <input type="checkbox"/> Both (6b) 2 <input type="checkbox"/> Layoff (6b)</p>
<p>6a. Earlier you said that -- worked last week or the week before. Ask 6b.</p> <p>b. For whom did -- work? Enter name of company, business, organization, or other employer.</p> <p>c. For whom did -- work at -- last full-time job or business lasting 2 consecutive weeks or more? Enter name of company, business, organization, or other employer or mark "NEV" or "AF" box in person's column</p> <p>d. What kind of business or industry is this? For example, TV and radio manufacturing, retail shoe store, State Labor Department, farm.</p> <p>e. What kind of work was -- doing? For example, electrical engineer, stock clerk, typist, farmer. If "AF" in 6b/c, mark "AF" box in person's column without asking.</p> <p>f. What were -- most important activities or duties at that job? For example, types, keeps account books, files, sells cars, operates printing press, finishes concrete.</p> <p>Complete from entries in 6b-f. If not clear, ask:</p> <p>g. Was --</p> <p>An employee of a PRIVATE company, business or individual for wages, salary, or commission? P Self-employed in OWN business, professional practice, or farm?</p> <p>A FEDERAL government employee? F Ask: Is the business incorporated?</p> <p>A STATE government employee? S Yes I</p> <p>A LOCAL government employee? L No SE</p> <p>Working WITHOUT PAY in family business or farm? WP</p> <p>NEVER WORKED or never worked at a full-time job lasting 2 weeks or more NEV</p>	<p>6b. and c.</p> <p>Employer</p> <p><input type="checkbox"/> NEV(6g) <input type="checkbox"/> AF(6e)</p> <p>d. Industry</p> <p>e. Occupation</p> <p><input type="checkbox"/> AF (NP)</p> <p>f. Duties</p> <p>g. Class of worker</p> <p>1 <input type="checkbox"/> P 5 <input type="checkbox"/> I 2 <input type="checkbox"/> F 6 <input type="checkbox"/> SE 3 <input type="checkbox"/> S 7 <input type="checkbox"/> WP 4 <input type="checkbox"/> L 8 <input type="checkbox"/> NEV</p>	
<p>FOOTNOTES</p>		

FORM HHS-1 (1984) (8-9-83)

L. DEMOGRAPHIC BACKGROUND PAGE, Continued

<p>Mark box if under 14. If "Married" refer to household composition and mark accordingly.</p> <p>7. Is -- now married, widowed, divorced, separated, or has -- never been married?</p>		7.	<p>0 <input type="checkbox"/> Under 14</p> <p>1 <input type="checkbox"/> Married -- spouse in HH</p> <p>2 <input type="checkbox"/> Married -- spouse not in HH</p> <p>3 <input type="checkbox"/> Widowed</p> <p>4 <input type="checkbox"/> Divorced</p> <p>5 <input type="checkbox"/> Separated</p> <p>6 <input type="checkbox"/> Never married</p>																																																												
<p>8a. Was the total combined FAMILY income during the past 12 months -- that is, yours, (read names, including Armed Forces members living at home) more or less than \$20,000? Include money from jobs, social security, retirement income, unemployment payments, public assistance, and so forth. Also include income from interest, dividends, net income from business, farm, or rent, and any other money income received.</p> <p>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</p> <p>-----</p> <p>Read parenthetical phrase if Armed Forces member living at home or if necessary.</p> <p>b. Of those income groups, which letter best represents the total combined FAMILY income during the past 12 months (that is, yours, (read names, including Armed Forces members living at home))? Include wages, salaries, and the other items we just talked about.</p> <p>Read if necessary: Income is important in analyzing the health information we collect. For example, this information helps us to learn whether persons in one income group use certain types of medical care services or have certain conditions more or less often than those in another group.</p>		8a.	<p>1 <input type="checkbox"/> \$20,000 or more (Hand Card I)</p> <p>2 <input type="checkbox"/> Less than \$20,000 (Hand Card J)</p>																																																												
<p>R</p> <p>a. Mark first appropriate box.</p> <p>-----</p> <p>b. Enter person number of respondent.</p>			<p>b.</p> <table border="0"> <tr><td>00 <input type="checkbox"/></td><td>A</td><td>10 <input type="checkbox"/></td><td>K</td><td>20 <input type="checkbox"/></td><td>U</td></tr> <tr><td>01 <input type="checkbox"/></td><td>B</td><td>11 <input type="checkbox"/></td><td>L</td><td>21 <input type="checkbox"/></td><td>V</td></tr> <tr><td>02 <input type="checkbox"/></td><td>C</td><td>12 <input type="checkbox"/></td><td>M</td><td>22 <input type="checkbox"/></td><td>W</td></tr> <tr><td>03 <input type="checkbox"/></td><td>D</td><td>13 <input type="checkbox"/></td><td>N</td><td>23 <input type="checkbox"/></td><td>X</td></tr> <tr><td>04 <input type="checkbox"/></td><td>E</td><td>14 <input type="checkbox"/></td><td>O</td><td>24 <input type="checkbox"/></td><td>Y</td></tr> <tr><td>05 <input type="checkbox"/></td><td>F</td><td>15 <input type="checkbox"/></td><td>P</td><td>25 <input type="checkbox"/></td><td>Z</td></tr> <tr><td>06 <input type="checkbox"/></td><td>G</td><td>16 <input type="checkbox"/></td><td>Q</td><td>26 <input type="checkbox"/></td><td>ZZ</td></tr> <tr><td>07 <input type="checkbox"/></td><td>H</td><td>17 <input type="checkbox"/></td><td>R</td><td></td><td></td></tr> <tr><td>08 <input type="checkbox"/></td><td>I</td><td>18 <input type="checkbox"/></td><td>S</td><td></td><td></td></tr> <tr><td>09 <input type="checkbox"/></td><td>J</td><td>19 <input type="checkbox"/></td><td>T</td><td></td><td></td></tr> </table>	00 <input type="checkbox"/>	A	10 <input type="checkbox"/>	K	20 <input type="checkbox"/>	U	01 <input type="checkbox"/>	B	11 <input type="checkbox"/>	L	21 <input type="checkbox"/>	V	02 <input type="checkbox"/>	C	12 <input type="checkbox"/>	M	22 <input type="checkbox"/>	W	03 <input type="checkbox"/>	D	13 <input type="checkbox"/>	N	23 <input type="checkbox"/>	X	04 <input type="checkbox"/>	E	14 <input type="checkbox"/>	O	24 <input type="checkbox"/>	Y	05 <input type="checkbox"/>	F	15 <input type="checkbox"/>	P	25 <input type="checkbox"/>	Z	06 <input type="checkbox"/>	G	16 <input type="checkbox"/>	Q	26 <input type="checkbox"/>	ZZ	07 <input type="checkbox"/>	H	17 <input type="checkbox"/>	R			08 <input type="checkbox"/>	I	18 <input type="checkbox"/>	S			09 <input type="checkbox"/>	J	19 <input type="checkbox"/>	T		
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<p>Ra.</p> <p>0 <input type="checkbox"/> Under 17</p> <p>1 <input type="checkbox"/> Present for all questions</p> <p>2 <input type="checkbox"/> Present for some questions</p> <p>3 <input type="checkbox"/> Not present</p> <p>-----</p> <p>b.</p> <p>Person number(s) of respondent(s)</p>																																																															
<p>FOOTNOTES</p>																																																															

M. HEALTH INSURANCE PAGE

Read to respondent(s):

Medicare is a Social Security health insurance program for disabled persons and for persons 65 years old and over. People covered by Medicare have a card that looks like this.
Show card.

1a. Is anyone in this family, that is (read names), now covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No (4) <input type="checkbox"/> DK		
b. Is --- now covered?		1b. <input type="checkbox"/> Covered <input type="checkbox"/> DK <input type="checkbox"/> Not covered
Ask for each person with "Covered" in 1b:		
2a. Is --- now covered by the part of Social Security Medicare which pays for hospital bills? Mark box in person's column.		2a. <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
b. Is --- now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which --- or some agency must pay a certain amount each month. Mark box in person's column.		b. <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> No
Ask for each person with "DK" in 2a and/or b:		
3. May I please see the Social Security Medicare card(s) for --- (and ---) to determine the type of coverage? Transcribe the information from the card or mark the "Card N.A." box.		3. <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Card N.A.
We are interested in all kinds of health insurance plans except those which pay only for accidents.		
4a. (Not counting Medicare) Is anyone in the family now covered by a health insurance plan which pays any part of a hospital, doctor's or surgeon's bill? <input type="checkbox"/> Yes <input type="checkbox"/> No (M1) <input type="checkbox"/> DK (M1)		
b. What is the name of the plan? Record in Table H.1.		
c. Is anyone in the family now covered by any other health insurance plan which pays any part of a hospital, doctor's or surgeon's bill? <input type="checkbox"/> Yes (Reask 4b and c) <input type="checkbox"/> No (5)		
TABLE H.1.		
PLAN 1 5a. Was this (name) plan obtained through an employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No (6) <input type="checkbox"/> DK (6)	6a. Does this plan pay any part of hospital expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	7. Is --- covered under this (name) plan?
b. Is it now carried through an employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	b. Does this plan pay any part of doctor's or surgeon's bills for operations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	7. <input type="checkbox"/> Covered (NP) <input type="checkbox"/> Not covered (NP)
PLAN 2 5a. Was this (name) plan obtained through an employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No (6) <input type="checkbox"/> DK (6)	6a. Does this plan pay any part of hospital expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	7. Is --- covered under this (name) plan?
b. Is it now carried through an employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	b. Does this plan pay any part of doctor's or surgeon's bills for operations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	7. <input type="checkbox"/> Covered (NP) <input type="checkbox"/> Not covered (NP)
PLAN 3 5a. Was this (name) plan obtained through an employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No (6) <input type="checkbox"/> DK (6)	6a. Does this plan pay any part of hospital expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	7. Is --- covered under this (name) plan?
b. Is it now carried through an employer or union? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	b. Does this plan pay any part of doctor's or surgeon's bills for operations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	7. <input type="checkbox"/> Covered (NP) <input type="checkbox"/> Not covered (NP)
M1 Review 1 and 7 for each person and determine if "Covered" by either Medicare and/or insurance, or "Not covered."	M1 <input type="checkbox"/> Covered (NP) <input type="checkbox"/> Not covered under 65 (NP) <input type="checkbox"/> Not covered 65 and over (NP)	
Ask for each person "Not covered" in M1. If "Not covered 65 and over," include "or Medicare."		
8a. (Many people do not carry health insurance for various reasons.) Hand Card M. Which of those statements describes why --- is not covered by any health insurance (or Medicare)? Any other reason?		8a. 1 2 3 4 5 6 7 8 Specify
Mark box if only one reason. If "Not covered 65 and over," in M1, include "or Medicare."		<input type="checkbox"/> Only one reason
b. What is the MAIN reason --- is not covered by any health insurance (or Medicare)?		b. 1 2 3 4 5 6 7 8 Specify

M. HEALTH INSURANCE PAGE, Continued

<p><i>Ask only if persons under 20 in family:</i></p> <p>9a. Does anyone in this family now receive assistance through the "Aid to Families with Dependent Children" Program, sometimes called "AFDC" or "ADC"?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (10) <input type="checkbox"/> DK</p> <p>b. Does --- now receive AFDC or ADC?</p>		<p>9b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>10a. Does anyone in this family now receive the "Supplemental Security Income" or "SSI" gold-colored check?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (11) <input type="checkbox"/> DK</p> <p>b. Does --- now receive this check?</p>		<p>10b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>11a. There is a national program called Medicaid which pays for health care for persons in need. (In this State it is also called <i>(name)</i>).</p> <p>During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid (or <i>(name)</i>)?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (12) <input type="checkbox"/> DK</p> <p>b. Has --- received this care in the past 12 months?</p>		<p>11b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>12a. Does anyone in the family now have a Medicaid (or <i>(name)</i>) card which looks like this? Show Medicaid card(s).</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (13) <input type="checkbox"/> DK</p> <p>b. Does --- now have this card?</p>		<p>12b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p><i>Ask for each person with "Yes" in 12b:</i></p> <p>c. May I please see --- (and ---) card(s)? <i>Mark appropriate box(es) in person's column.</i></p>		<p>c.</p> <p><input type="checkbox"/> Medicaid card seen 1 <input type="checkbox"/> Current 2 <input type="checkbox"/> Expired 3 <input type="checkbox"/> No card seen 8 <input type="checkbox"/> Other card seen</p> <p style="text-align: center;">Specify _____</p>
<p>13a. Is anyone in the family now covered by any other public assistance program that pays for health care?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (Next page) <input type="checkbox"/> DK</p> <p>b. Is --- now covered?</p>		<p>13b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>

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M. HEALTH INSURANCE PAGE, Continued

<p>14a. Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans Administration? Do not include VA disability compensation.</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No (15) <input type="checkbox"/> DK </p> <hr style="border-top: 1px dashed black;"/> <p>b. Does --- now receive military retirement or a VA pension?</p> <p><i>Ask for each person with "Yes" in 14b:</i></p> <p>c. Which does --- receive -- the Armed Forces retirement, the VA pension or both? <i>Mark box in person's column.</i></p>		<p>14b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <hr style="border-top: 1px dashed black;"/> <p>c.</p> <p>1 <input type="checkbox"/> Armed Forces 2 <input type="checkbox"/> VA 3 <input type="checkbox"/> Both</p>
<p>15a. Is anyone in the family now covered by CHAMP--VA, which is medical insurance for dependents or survivors of disabled veterans?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No (16) <input type="checkbox"/> DK </p> <hr style="border-top: 1px dashed black;"/> <p>b. Is --- now covered by CHAMP--VA?</p>		<p>15b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>16a. Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No (M2) <input type="checkbox"/> DK </p> <hr style="border-top: 1px dashed black;"/> <p>b. Is --- now covered?</p>		<p>16b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>
<p>M2 <i>Refer to "AF" box above person's column.</i></p>		<p>M2</p> <p>1 <input type="checkbox"/> AF box marked (17) 2 <input type="checkbox"/> Other (NP)</p>
<p>17a. Does --- have a disability related to --- service in the Armed Forces of the United States?</p> <hr style="border-top: 1px dashed black;"/> <p>b. Does --- now receive compensation for this disability from the Veterans Administration?</p>		<p>17a.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)</p> <hr style="border-top: 1px dashed black;"/> <p>b.</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>FOOTNOTES</p>		

FORM HIS-1 (1984) (8-9-83)

M. HEALTH INSURANCE PAGE, Continued

<p>18a. During the past 12 months, that is since (12-month date) a year ago, have (read names of related HH members 18 or over) been laid off from a job or lost a job?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No (M4) <input type="checkbox"/> DK (M4)</p>		
<p>b. Who was this? Mark "Laid off/lost job" box in person's column.</p>		18b. 1 <input type="checkbox"/> Laid off/lost job
<p>c. Anyone else?</p> <p style="text-align: right;"><input type="checkbox"/> Yes (Reask 18b and c) <input type="checkbox"/> No</p> <p><i>Ask 18d, e, and f for each person with "Laid off/lost job" in 18b.</i></p>		
<p>d. How many times has -- been laid off or lost a job during the past 12 months?</p>		d. _____ Times
<p>e. In what month was -- laid off or did -- lose a job (the last time/the time before that)?</p>		e. <input type="text"/> Time 1 <input type="text"/> Time 2 <input type="text"/> Time 3
<p>f. For ANYTIME during (that/those) job layoff(s) or job loss(es), did -- receive unemployment insurance benefits?</p>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
<hr/>		
<p>19a. Because of (names of persons in 18b) job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through (that/those) job(s)?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No (M4) <input type="checkbox"/> DK (M4)</p>		
<p>b. Who was this? Mark "Lost coverage" box in person's column.</p>		19b. 1 <input type="checkbox"/> Lost coverage
<p>c. Anyone else?</p> <p style="text-align: right;"><input type="checkbox"/> Yes (Reask 19b and c) <input type="checkbox"/> No</p>		
<hr/>		
M3	Refer to 19b and mark appropriate box.	M3 1 <input type="checkbox"/> Lost coverage (20) 2 <input type="checkbox"/> Did not lose coverage (NP)
<p>20a. For ANYTIME during (that/those) job layoff(s) or job loss(es), was -- without any type of health insurance coverage? (Do not include health care programs, such as Medicaid, AFDC, or military benefit programs, as health insurance coverage.)</p>		20a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
<p>b. For how long was -- without some type of health insurance coverage? (How many months is that?)</p>		b. 00 <input type="checkbox"/> Less than 1 month _____ Months
<p>21a. For ANYTIME during (that/those) job layoff(s) or job loss(es), was -- covered by any health care program, such as Medicaid, AFDC, or a military benefit program?</p>		21a. 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (NP)
<p>b. For how long was -- covered by some health care program? (How many months is that?)</p>		b. 00 <input type="checkbox"/> Less than 1 month _____ Months
<hr/>		
M4	Refer to age(s) and mark appropriate box.	M4 1 <input type="checkbox"/> No person 55+ in family (HH pg.) 6 <input type="checkbox"/> Other (Supplement on Aging)

FORM HIS-1 (1984) (8-9-83)