

Appendix II

1984 Supplement on Aging

Questionnaire

OMB No. 0937-0021: Approval Expires March 31, 1985

FORM HIS-1(SB) (1984)
(3.13.84)

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

NATIONAL HEALTH INTERVIEW SURVEY

SUPPLEMENT BOOKLET

NOTICE: Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1. Book _____ of _____ books **RT 60** **2.** R.O. Number **3-4** **3.** Sample **6-7**

4. Control number PSU **8-10** Segment **11-14** Serial **15-18**

5. Person number **17-18** **6.** Sex **19** **7.** Sample Person name **20-39** **40-54** Middle **55**
Last First initial
1 Male
2 Female

8. Final status of supplement **56**
Interview
0 No SP selected
1 Complete interview (all appropriate pages completed)
2 Partial interview (some but not all appropriate pages completed) (Explain in notes)
Noninterview
3 Refused (Explain in notes)
4 SP temporarily absent, no proxy available
5 SP, mentally or physically incapable, no proxy available
8 Other (Explain in notes)

9. Date supplement completed **57-60** **10.** Interviewer identification **61-62**
Name Code
Month Date

NOTES

CONTACT PERSON INFORMATION

Contact information for this family unit already obtained, transcribe when editing. Fill item 15 below, THEN go to HIS-1 Household Page or next SOA.
Read to SOA respondent at end of interview - The National Center for Health Statistics may wish to contact you again to obtain additional health related information. Please give me the name, address, and telephone number of a close relative or friend who would know where you could be reached in case we have trouble reaching you. (Please give me the name of someone who is not currently living in the household.) Please print items 11, 12, 14. **RT 62** **3-4**

11. Contact Person name **RT 61** **3-4** **5-24** **25-39** **40** **13.** Area code/telephone number **5-14**
Last First Middle initial
1 None 2 Refused 9 DK **15**

12a. Address (Number and street) **41-65** **14.** Relationship to Sample Person **16-17**

b. City **66-85** State **86-87** Zip Code **88-96** **15.** Supplement ending time **18-21** **22**
Hour Minutes { 1 a.m. }
2 p.m. Go to HIS-1 Household Page or next SOA

TRANSCRIPTION FROM HIS-1

16. Area code/telephone number from HIS 1, item 11 **23-32** **17b.** Mailing address from HIS 1, item 6b 1 Same as 6a on HIS-1 **5** **6-30**
Number and street

17a. Exact address from HIS-1, item 6a (Please print items 17a-c) **33** **34-58**
Number and street/description

City **31-50** State **51-52** Zip Code **53-61**

c. Special Place name (Fill if applicable) **62-97**

SUPPLEMENT ON AGING SAMPLE SELECTION

Use Table A or B as indicated on HIS-1 Household Composition Page. Circle that letter and enter number below to indicate the order of interview (1 = down from the top of the listing, 2 = up from the bottom). Follow this order whenever two or more sample persons are at home at the same time. **RT 64** **3-4**

18. Are there any nondeleted persons 65 years old or older in the family? 1 Yes (List by age (oldest to youngest) in upper portion of appropriate table, mark "SP" box on HIS-1 for each, THEN 19) **5**
2 No (19)

19. Are there any nondeleted persons 55-64 years old in the family? 1 Yes (List by age (oldest to youngest) in lower portion of appropriate table, mark "SP" box on HIS-1 for each "X" person, and begin supplement using the appropriate "order of interview") **6**
2 No (Begin interview(s) using the appropriate "order of interview")

TABLE A				TABLE B			
Age	Name	Person number	Sample person	Age	Name	Person number	Sample person
7-8		9-10	X	39-40		41-42	X
11-12		13-14	X	43-44		45-46	X
15-16		17-18	X	47-48		49-50	X
19-20		21-22	X	51-52		53-54	X
23-24		25-26	X	55-56		57-58	
27-28		29-30		59-60		61-62	X
31-32		33-34	X	63-64		65-66	
35-36		37-38		67-68		69-70	X

SUPPLEMENT ON AGING		RT 66 3-4			
Section N. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT, AND LIVING ARRANGEMENTS					
N1	a. Initial status of sample person	<input type="checkbox"/> Available (N1b) <input type="checkbox"/> Callback required (Next SP)			
	b. Supplement beginning time	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black;">Hour</td> <td style="width: 15%; border: 1px solid black;">Minutes</td> <td style="width: 10%; border: 1px solid black;">}</td> <td style="width: 60%;"> <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. </td> </tr> </table>	Hour	Minutes	}
Hour	Minutes	}	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
<p>Read to respondent — We are interested in obtaining further information about the health of people 55 years of age and older in the United States. I will also ask you some questions about your family and social activities.</p>					
<p>Ask or verify for each HH member</p> <p>1. How is (name on HIS-1) related to you?</p> <p>Enter "Sample Person" on appropriate line. Enter "Unrelated" for persons not related to the sample person. Enter "Deleted" for any deleted persons, except AF members living at home and babies born during interview week. Enter ages from HIS-1.</p>					
		5			
		6-9 10			
		71			
N2	Refer to marital status (page 46 or 47) on HIS-1	<input type="checkbox"/> Sample person is now married (N3) <input type="checkbox"/> Sample person is now widowed, divorced, separated (2b) <input type="checkbox"/> Sample person has never been married (6)			
N3	Spouse of Sample Person previously interviewed on SOA	<input type="checkbox"/> Yes (6) <input type="checkbox"/> No (2)			
2a. How long have you been married (to (name of spouse))?		72			
<input type="checkbox"/> Less than one year _____ Number of years } (3)		73-74			
b. Earlier [you told me/I was told] that you are now [widowed/divorced/separated]. How long have you been [widowed/divorced/separated]?		75-76			
<input type="checkbox"/> Less than one year _____ Number of years		77-78			
3a. Including step and adopted children, how many LIVING children do you have?		79-80			
<input type="checkbox"/> None (6) _____ Number		81-82			
b. How many of your children are sons and how many are daughters?		83-84			
_____ Number of sons _____ Number of daughters <input type="text"/> Total number of children Compare with 3a, reconcile differences		85			
N4	Refer to relationship roster in 1	<input type="checkbox"/> Any of SP's children live in household (6) <input type="checkbox"/> Other (4)			
FOOTNOTES					

Section N. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT, AND LIVING ARRANGEMENTS, Continued		
4a. How quickly can [any one of your children/your son/your daughter] get here?	_____ Number $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Minutes} \\ 2 \text{ } \square \text{ Hours} \\ 3 \text{ } \square \text{ Days} \end{array} \right.$	86-88
b. How often do you see [any one of your children/your son/your daughter]?	000 <input type="checkbox"/> Less than once a year/never _____ Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$	89-91
c. How often do you talk on the telephone with [any one of your children/your son/your daughter]?	000 <input type="checkbox"/> Less than once a year/never _____ Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$	92-94
d. How often do you get mail from [any one of your children/ your son/your daughter]?	000 <input type="checkbox"/> Less than once a year/never _____ Times per $\left\{ \begin{array}{l} 1 \text{ } \square \text{ Day} \\ 2 \text{ } \square \text{ Week} \\ 3 \text{ } \square \text{ Month} \\ 4 \text{ } \square \text{ Year} \end{array} \right.$	95-97
5. [Do your children/Does your son/Does your daughter] routinely give you money to help with your living expenses or pay your bills?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	98
6a. Including step and adopted brothers, how many LIVING brothers do you have?	00 <input type="checkbox"/> None _____ Number of brothers	99-100
b. Including step and adopted sisters, how many LIVING sisters do you have?	00 <input type="checkbox"/> None _____ Number of sisters	101-102
7. How long have you been living here, in this [house/apartment]?	00 <input type="checkbox"/> Less than 1 year _____ Number of years	103-104
N5 Other family member previously interviewed on SOA	1 <input type="checkbox"/> Yes (12) 2 <input type="checkbox"/> No (8)	105
Mark if known 8. Is this [house/apartment] in a RETIREMENT [community/building or complex]?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (10)	106
9. Whether you use them or not, are the following services available in THIS retirement [community/building or complex]?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	107
a. Group meals for residents?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	108
b. Housekeeping or maid service?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	109
c. Medical services?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	110
d. Telephone call service to check on your well-being?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	111
e. Recreational services?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	112
10a. Is it NECESSARY to go up or down a step to get into this [house/apartment] from the outside?	1 <input type="checkbox"/> No Yes - If not mentioned, ask: Is it one or more than one? 2 <input type="checkbox"/> 1 step 3 <input type="checkbox"/> More than 1 step	113
b. Counting basements and stepdown living areas as separate levels, does this [house/apartment] have more than one floor or level?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (11b)	

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Section N. FAMILY STRUCTURE, RELATIONSHIPS, SUPPORT, AND LIVING ARRANGEMENTS, Continued		RT 66				
		3-4				
11a. Does this [house/apartment] have a bathroom, bedroom, and kitchen ALL on the SAME floor or level?		5				
1 b. Does this [house/apartment] have a walk-in shower, that is, where you don't step over the side of the tub to get into the shower?		6				
12a. Because of a health or physical problem, do YOU NEED a bathroom, bedroom, and kitchen all on the same floor or level?		7				
1 b. Because of a health or physical problem, do YOU NEED a walk-in shower?		8				
N6	Mark first appropriate box	9				
		10				
13a. Do you and (read names of all other household members) live together NOW because YOU need to share living expenses?		10				
1 b. Do you and (read names of all other household members) live together NOW because of a health or physical problem YOU have?		11				
N7	Spouse of SP previously interviewed on SOA	12				
		13				
14a. Is this [house/apartment] now --						
(1) Owned or being bought by you (OR someone in the household)?		13				
(2) Rented for money?		14				
(3) Occupied without payment of money rent?		15				
b. Who owns or is buying it? Anyone else? Follow skip instructions for lowest numbered box marked.	1 Sample person	16				
	2 Spouse		17			
	3 Child			18		
	4 Grandchild				19	
	5 Other relative					20
	6 Nonrelative					
c. Is this place fully paid for or is there a mortgage being paid?		22				
d. Do you know about how much principal is still owed on the mortgage?		23				
e. How much principal is still owed?		24-29				
\$ _____ Amount						
f. Do you know the present value of this place, that is, about how much it would bring if you sold it on today's market?		30				
g. What is the present value?		31-36				
\$ _____ Amount (Section O)						
h. Who is paying rent for it? Anyone else?	1 Sample person	37				
	2 Spouse		38			
	3 Child			39		
	4 Grandchild				40	
	5 Other relative					41
	6 Nonrelative					
FOOTNOTES						

Section O. COMMUNITY AND SOCIAL SUPPORT

01	Refer to age	1 <input type="checkbox"/> Sample person is 55-59 (3) 2 <input type="checkbox"/> Sample person is 60 or older (1)	43
NOTE — Ask 2 immediately after receiving a "Yes" in 1. Read to respondent — The next questions are about community services.		2. How often did you use it — frequently, sometimes, or rarely?	
1. In the past 12 months, did YOU — a. Use a senior center?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	44
b. Use special transportation for the elderly?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	46
c. Have meals delivered to your home by an agency or organization like Meals on Wheels?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	48
d. Eat meals in a senior center or in some place with a special meal program for the elderly?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	50
e. Use a homemaker service for the elderly that provides services like cleaning and cooking in the home?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	52
f. Use a service which makes routine telephone calls to check on the health of elderly people?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	54
g. Use a visiting nurse service?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	56
h. Use a health aide who comes into the home?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (Next service)	58
i. Use adult day care or day care for the elderly?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (3)	60
3a. In the past 12 months, did you do any volunteer work for any organized group?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK } (4)	62
b. How often did you do volunteer work — frequently, sometimes, or rarely?		1 <input type="checkbox"/> Frequently 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely	63
Hand Calendar Read to respondent — The next questions refer to the 2 weeks (outlined in red on that calendar), beginning Monday (date) and ending this past Sunday (date).			
4. During those 2 weeks did you — a. Get together socially with friends or neighbors?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	64
b. Talk with friends or neighbors on the telephone?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	65
c. Get together with ANY relatives (not including household members)?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	66
d. Talk with ANY relatives on the telephone (not including household members)?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	67
e. Go to church or temple for services or other activities?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	68
f. Go to a show or movie, sports event, club meeting, classes or other group event?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	69
02	Respondent	1 Self (5) 2 Proxy (Section P)	70
5. Regarding your present social activities, do you feel that you are doing about enough, too much, or would you like to be doing more?		1 <input type="checkbox"/> About enough 2 <input type="checkbox"/> Too much 3 <input type="checkbox"/> Would like to do more	71

Section P. OCCUPATION AND RETIREMENT		RT 67	
		3-4	
P1	Refer to Wa/Wb boxes for SP in C1 on the HIS-1, Household Composition Page	1 <input type="checkbox"/> Wa or Wb marked (1d) 8 <input type="checkbox"/> Other (1a)	5
1a. Have you EVER worked at a job or business?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)	6
b. Have you worked at a job or business, at any time since you were 45 years old?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2) 9 <input type="checkbox"/> DK } (2)	7
c. Did you work at all at a job or business in the past 12 months, that is, since (12 month date) a year ago?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2)	8
d. Since (12 month date) a year ago, in how many weeks did you work, either full or part time, not counting work around the house? Include paid vacations and paid sick leave.		52 <input type="checkbox"/> All year - 52 weeks _____ Weeks	9-10
e. In the weeks that you worked, how many hours a week did you USUALLY work at ALL jobs?		_____ Hours	11-12
2a. At this time, do you consider yourself completely retired, partly retired, or not retired at all?		1 <input type="checkbox"/> Completely retired 2 <input type="checkbox"/> Partly retired 3 <input type="checkbox"/> Not retired at all 4 <input type="checkbox"/> Never worked } (3)	13
P2	Refer to SP's work status in 1a and 1b	1 <input type="checkbox"/> "No" in 1a or 1b (3) 8 <input type="checkbox"/> All other (2b)	14
2b. Have you retired more than once?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	15
c. How long has it been since you retired (the last time)?		00 <input type="checkbox"/> Less than 1 year _____ Number of years	16-17
d. (The last time you retired) Did you retire mainly because of a health or physical problem you had?		1 <input type="checkbox"/> Yes (3) 2 <input type="checkbox"/> No	18
e. (That time) Did you retire mainly because you thought your work would cause a health problem?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	19
3a. (Even though you do not consider yourself retired) Are you NOW receiving RETIREMENT income from any of these sources? Do NOT include any disability income.		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	20
b. Which ones? Mark all sources given		Note - Ask 4 and 5 for each source marked in 3b	
Any other source?		4. How long have you been receiving (source in 3b)?	5. Do you NOW receive it because of your OWN work experience or because you are a dependent or survivor of someone else?
1 <input type="checkbox"/> Social Security	21	00 <input type="checkbox"/> Less than 1 year _____ Number of years	22-23
2 <input type="checkbox"/> Railroad retirement	25	00 <input type="checkbox"/> Less than 1 year _____ Number of years	24
3 <input type="checkbox"/> A private employer or union pension	29	00 <input type="checkbox"/> Less than 1 year _____ Number of years	26-27
4 <input type="checkbox"/> A government employee pension (Federal, State, or local)	33	00 <input type="checkbox"/> Less than 1 year _____ Number of years	28
5 <input type="checkbox"/> Military retirement	37	00 <input type="checkbox"/> Less than 1 year _____ Number of years	29-31
6 <input type="checkbox"/> Some other source - Specify	41	FOOTNOTES	30-31
	42-43		32
			33
			34-35
			36
			37
			38-39
			40
			41
			42-43

Section P. OCCUPATION AND RETIREMENT, Continued

6. Are you now receiving disability payments from any source?		44
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (9)		
7. Are you receiving disability payments because of a disability YOU have or because you are a dependent or survivor of someone else?		45
1 <input type="checkbox"/> Own 2 <input type="checkbox"/> Someone else (9) 3 <input type="checkbox"/> Both		
8. How long have you been receiving disability payments?		46-47
00 <input type="checkbox"/> Less than 1 year _____ Number of years <i>If more than one, record the longest one.</i>		
9. Have you EVER received any disability payments from Social Security?		48
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK		
Note — Ask 10a-j before asking 11 and 12.		Note — Ask 11 and 12 for each "Yes" in 10a-j.
<i>Read to respondent —</i>		11. How much difficulty do you have (activity in 10), some, a lot, or are you unable to do it?
Please tell me if you have ANY difficulty when you do the following activities —		12. For how long have you [had some difficulty/had a lot of difficulty/been unable to] (activity in 10)?
10. By yourself and not using aids, do you have any difficulty —	49	50
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable
a. Walking for a quarter of a mile (that is about 2 or 3 blocks)?	53	54
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
b. Walking up 10 steps without resting?	57	58
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
c. Standing or being on your feet for about 2 hours?	61	62
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
d. Sitting for about 2 hours?	65	66
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
<i>Reask 10</i>		67-68
e. Stooping, crouching, or kneeling?	69	70
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
f. Reaching up over your head?	73	74
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
g. Reaching out (as if to shake someone's hand)?	77	78
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
<i>Reask 10</i>		79-80
h. Using your fingers to grasp or handle?	81	82
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
i. Lifting or carrying something as heavy as 25 pounds (such as two full bags of groceries)?	85	86
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (11) 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years
j. Lifting or carrying something as heavy as 10 pounds?	85	86
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> NA/DK		00 <input type="checkbox"/> Less than 1 year _____ Number of years

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Section P. OCCUPATION AND RETIREMENT, Continued		
P3	Refer to Wa/Wb boxes for SP in C1 on the HIS-1 Household Composition Page	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Wa or Wb box marked (Section Q) <input type="checkbox"/> Other (P4) </div> <div style="border: 1px solid black; padding: 2px;">89</div> </div>
P4	Mark first appropriate box	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> SP is 75+ } (Section Q) <input type="checkbox"/> Proxy } <input type="checkbox"/> Self response (T3) </div> <div style="border: 1px solid black; padding: 2px;">90</div> </div>
13a. Do you think there are some kinds of work you could do now if jobs were available?		<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/maybe } (Section Q) </div> <div style="border: 1px solid black; padding: 2px;">91</div> </div>
b. Do you WANT to work at a job or business?		<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="border: 1px solid black; padding: 2px;">92</div> </div>
FOOTNOTES		

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Section Q. CONDITIONS AND IMPAIRMENTS

Read to respondent — Now tell me if you have any of these eye conditions, even if you have mentioned them before.		
1. Do you NOW have —		5
a. Cataracts?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	
b. Glaucoma?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	6
c. Color blindness?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	7
d. A detached retina or any other condition of the retina? <i>Circle appropriate condition</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	8
e. Blindness in one or both eyes? <i>If "Yes," ask: Which — one or both?</i>	Yes 0 <input type="checkbox"/> One 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Both (Q1)	9
f. Any other trouble seeing with one or both eyes EVEN when wearing glasses?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	10
Q1	<i>Refer to answers in 1a-f</i>	11
	1 <input type="checkbox"/> All "No" or "DK" in 1a-f (2) 8 <input type="checkbox"/> Other — Enter "Yes" responses in EYE LTR box on Condition Summary Chart, THEN Q2	
Q2	<i>Blindness in BOTH eyes reported in 1e</i>	12
	1 <input type="checkbox"/> Yes (4a THEN 9) 2 <input type="checkbox"/> No (2)	
2a. Do you use eyeglasses? Include eyeglasses that just magnify.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (3)	13
b. Were these eyeglasses prescribed for you?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	14
3. Do you use contact lenses?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	15
4a. Have you ever had an operation for cataracts?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	16
b. Do you have a lens implant?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	17
5. Do you use a magnifying glass to read or to do other close work?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	18
Read to respondent — The next few questions are about how well you can see (wearing your [glasses/(or) contact lenses] if that's how you see best).		
6a. Can you see well enough to recognize the features of people if they are within two or three feet?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	19
b. Can you see well enough to watch T.V. 8 to 12 feet away?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	20
c. Can you see well enough to read newspaper print?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	21
7a. Can you see well enough to step off a curb or down a step?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	22
b. Can you see well enough to recognize a friend walking on the other side of the street?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	23
8. Which statement best describes your vision (wearing [glasses/(or) contact lenses]) — no trouble seeing, a little trouble, or a lot of trouble?	1 <input type="checkbox"/> No trouble 2 <input type="checkbox"/> Little trouble 3 <input type="checkbox"/> Lot of trouble	24

Section Q. CONDITIONS AND IMPAIRMENTS, Continued		
<i>Read to respondent — These next questions are about hearing.</i>		25
9. Do you NOW have —		
a. Tinnitus or ringing in the ears? <i>Circle appropriate condition.</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	26
b. Deafness in one or both ears? <i>If "Yes," ask: Which — one or both?</i>	Yes 0 <input type="checkbox"/> One 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK 1 <input type="checkbox"/> Both (Q3)	27
c. Any other trouble hearing with one or both ears?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	28
Q3	<i>Refer to answers in 9a—c</i>	1 <input type="checkbox"/> All "No" or "DK" in 9a—c (10) 8 <input type="checkbox"/> Other — Enter "Yes" responses in EAR LTR box on Condition Summary Chart, THEN 10
10a. Do you use a hearing aid?		
	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	29
b. (With your hearing aid) Can you hear MOST of the things people say?	1 <input type="checkbox"/> Yes (11) 2 <input type="checkbox"/> No	30
c. (With your hearing aid) Can you hear ONLY A FEW WORDS people say or LOUD noises?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	31
11. Which statement best describes your hearing (with your hearing aid) — no trouble hearing, a little trouble, or a lot of trouble?		
	1 <input type="checkbox"/> No trouble 2 <input type="checkbox"/> Little trouble 3 <input type="checkbox"/> Lot of trouble	32
<i>Read to respondent — Please tell me if you have EVER had any of the following conditions, even if you have mentioned them before.</i>		
12. Have you EVER had —		
a. Osteoporosis, sometimes called fragile or soft bones? <i>(os tee o po ro' sis)</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	33
b. A broken hip?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	34
c. Hardening of the arteries or arteriosclerosis? <i>Circle appropriate condition</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	35
d. Hypertension, sometimes called high blood pressure?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	36
e. Rheumatic fever?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	37
f. Rheumatic heart disease?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	38
g. Coronary heart disease?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	39
h. Angina pectoris? <i>(pek' to ris)</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	40
i. A myocardial infarction?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	41
j. Any other heart attack?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	42
k. A stroke or a cerebrovascular accident? <i>(ser' a-bro vas ku lar)</i> <i>Circle appropriate condition</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	43
l. Alzheimer's disease? <i>(al' zi mers)</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	44
m. Cancer of any kind?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK	45
Q4	<i>Refer to answers in 12a—m</i>	1 <input type="checkbox"/> All "No" or "DK" in 12a—m (13) 8 <input type="checkbox"/> Other — Enter "Yes" responses in EVER LTR box on Condition Summary Chart, THEN 13

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Section Q. CONDITIONS AND IMPAIRMENTS, Continued

<p>13. During the PAST 12 MONTHS, did you have —</p> <p>a. Arthritis of any kind or rheumatism? <i>Circle appropriate condition</i></p> <p>b. Diabetes?</p> <p>c. An aneurysm? (an' yoo rizm)</p> <p>d. Any blood clots?</p> <p>e. Varicose veins?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> DK</p>	<p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p>						
<p>Q5 Refer to answers in 13a—e</p>	<p>1 <input type="checkbox"/> All "No" or "DK" in 13a—e (14)</p> <p>8 <input type="checkbox"/> Other — Enter "Yes" responses in 12-MO LTR box on Condition Summary Chart, THEN 14</p>	<p>52</p>						
<p>14a. During the past 12 months, that is, since (12-month date) a year ago, have you fallen?</p> <p>b. How many times?</p> <p>c. (Did you fall/Were any of these falls) because you felt dizzy?</p> <p>d. Do you sometimes have trouble with dizziness?</p> <p>e. Does dizziness prevent you in any way from doing things you otherwise could do?</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (14d)</p> <p>1 <input type="checkbox"/> One 2 <input type="checkbox"/> More than one</p> <p>1 <input type="checkbox"/> Yes (14e) 2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (15)</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p>						
<p>15. Do you have trouble biting or chewing any kinds of food, such as firm meat or apples? <i>If asked — includes wearing false teeth/dentures.</i></p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>58</p>						
<p><i>Read to respondent — In order to determine how health practices and conditions are related to how long people live, we would like to refer to statistical records maintained by the National Center for Health Statistics.</i></p>								
<p>RT 69 3-4</p>								
<p>16a. I have your date of birth as (birthdate from item 3 on HIS-1 Household Composition page). Is that correct?</p>	<p>Date of birth</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Month</td> <td style="width:33%;">Date</td> <td style="width:33%;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	Month	Date	Year				<p>5-11</p>
Month	Date	Year						
<p>b. In what State or country were you born?</p> <p><i>Write in the full name of the State or mark the appropriate box if the sample person was not born in the United States.</i></p>	<p>99 <input type="checkbox"/> DK</p> <p>_____ State</p> <p>01 <input type="checkbox"/> Puerto Rico 05 <input type="checkbox"/> Cuba 02 <input type="checkbox"/> Virgin Islands 06 <input type="checkbox"/> Mexico 03 <input type="checkbox"/> Guam 98 <input type="checkbox"/> All other countries 04 <input type="checkbox"/> Canada</p>	<p>12-13</p>						
<p>c. To verify the spelling, what is your full name, including middle initial?</p>	<p>Last</p> <p>_____</p> <p>First</p> <p>_____</p> <p>Middle initial</p> <p>_____</p>	<p>14-33</p> <p>34-48</p> <p>49</p>						
<p><i>Verify for males; ask for females.</i></p> <p>d. What was your father's LAST name? <i>Verify spelling. DO NOT write "Same."</i></p>	<p>_____ Father's LAST name</p>	<p>50-69</p>						
<p><i>Read to respondent — We also need your Social Security Number. This information is voluntary and collected under the authority of the Public Health Service Act. There will be no effect on your benefits and no information will be given to any other government or nongovernment agency.</i></p> <p><i>Read if necessary — The Public Health Service Act is title 42, United States Code, section 242k.</i></p>	<p>99999999 <input type="checkbox"/> DK</p> <p>____-____-____</p> <p>Social Security Number</p>	<p>70-78</p>						
<p>e. What is your Social Security Number?</p>	<p>Mark if number obtained from → 1 <input type="checkbox"/> Memory 2 <input type="checkbox"/> Records</p>	<p>79</p>						

Section R1. ACTIVITIES OF DAILY LIVING (ADL'S)

Read to respondent – The next questions are about how well you are able to do certain activities – by yourself and without using special equipment.

<p>1. Because of a health or physical problem, do you have ANY difficulty –</p> <p>Ask if "Doesn't do": Is this because of a HEALTH or PHYSICAL problem?</p> <p>If "Yes," mark box 1; if "No," mark box 3</p>	<p>(1) 5</p>	<p>Bathing or showering?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason</p>	<p>(2) 22</p>	<p>Dressing?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason</p>	<p>(3) 39</p>	<p>Eating?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason</p>						
<p>Ask 2-5 for each ADL marked "Yes" in 1.</p> <p>2. By yourself and without using special equipment, how much difficulty do you have (ADL), some, a lot, or are you unable to do it?</p>	<p>6</p>	<p>1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable</p>	<p>23</p>	<p>1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable</p>	<p>40</p>	<p>1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable</p>						
<p>3. Do you receive help from another person in (ADL)?</p>	<p>7</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)</p>	<p>24</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)</p>	<p>41</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)</p>						
<p>4a. Who gives this help?</p> <p>Anyone else?</p> <p>Mark the S/C/P box without asking if ONLY help is from spouse/children/parents.</p> <p>b. Is this help paid for?</p> <p>Ask if necessary: Which helpers are paid?</p>	<p>8-11</p>	<p>4a. Source of help</p> <p>HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative</p> <p>Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative</p>	<p>12-15</p>	<p>4b. Paid</p> <p>0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>25-28</p>	<p>4a. Source of help</p> <p>HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative</p> <p>Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative</p>	<p>29-32</p>	<p>4b. Paid</p> <p>0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>42-45</p>	<p>4a. Source of help</p> <p>HH member 1 <input type="checkbox"/> Relative 2 <input type="checkbox"/> Nonrelative</p> <p>Non-HH member 3 <input type="checkbox"/> Relative 4 <input type="checkbox"/> Nonrelative</p>	<p>46-49</p>	<p>4b. Paid</p> <p>0 <input type="checkbox"/> S/C/P (5) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p>5a. Do you use any special equipment or aids in (ADL)?</p>	<p>16</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)</p>	<p>33</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)</p>	<p>50</p>	<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)</p>						
<p>b. What special equipment or aids do you use?</p> <p>Anything else?</p>	<p>17-18</p>	<p>Special equipment or aids</p> <p>_____</p> <p>_____</p>	<p>19-20</p>	<p>34-35</p>	<p>36-37</p>	<p>Special equipment or aids</p> <p>_____</p> <p>_____</p>						
<p>Ask 6 if any ADL marked "Yes" in 1.</p> <p>6a. What (other) condition causes the trouble in (read ADL(s))?</p> <p>Ask if injury or operation: When did [the injury] occur? / you have the operation?</p> <p>Enter injury if over 3 months ago.</p> <p>Ask or reask 6b, if 0-3 months injury or operation.</p> <p>Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</p>	<p>6c</p>	<p><input type="checkbox"/> Old age (6c)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>6d</p>	<p><input type="checkbox"/> Yes (Reask 6a and b) <input type="checkbox"/> No (6d)</p>	<p>6e</p>	<p><input type="checkbox"/> Yes (Reask 6a and b) <input type="checkbox"/> No</p>						
<p>If multiple conditions, including old age, are listed in 6a, ask 6d for each ADL with a "Yes" in 1. Otherwise, mark appropriate box or transcribe the only listed condition for each ADL.</p> <p>d. Which of these conditions, that is (read conditions in 6a) would you say is the MAIN cause of the trouble in (ADL)?</p>	<p>(1) 21</p>	<p>1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age</p> <p>Ask 6d for next ADL with "Yes" in 1</p> <p>3 <input type="checkbox"/> _____</p> <p>Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.</p>	<p>(2) 38</p>	<p>1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age</p> <p>Ask 6d for next ADL with "Yes" in 1</p> <p>3 <input type="checkbox"/> _____</p> <p>Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.</p>	<p>(3) 55</p>	<p>1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age</p> <p>Ask 6d for next ADL with "Yes" in 1</p> <p>3 <input type="checkbox"/> _____</p> <p>Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.</p>						

FOOTNOTES

Section R1. ACTIVITIES OF DAILY LIVING (ADL'S), Continued

Reask 1 (4) 56 Getting in and out of bed or chairs? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		(5) 73 Walking? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		(6) 90 Getting outside? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		(7) 5 Using the toilet, including getting to the toilet? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
57 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		74 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		91 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		6 1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
58 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		75 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		92 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)		7 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (5)	
4a. Source of help 4b. Paid HH member 59-62 63-66 1 <input type="checkbox"/> Relative 0 <input type="checkbox"/> S/C/P (5) 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		4a. Source of help 4b. Paid HH member 76-79 80-83 1 <input type="checkbox"/> Relative 0 <input type="checkbox"/> S/C/P (5) 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		4a. Source of help 4b. Paid HH member 93-96 97-100 1 <input type="checkbox"/> Relative 0 <input type="checkbox"/> S/C/P (5) 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		4a. Source of help 4b. Paid HH member 8-11 12-15 1 <input type="checkbox"/> Relative 0 <input type="checkbox"/> S/C/P (5) 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
67 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)		84 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)		101 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (2 for next ADL with "Yes" in 1)		16 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (6)	
Special equipment or aids _____ 68-69 _____ 70-71		Special equipment or aids _____ 85-86 _____ 87-88		Special equipment or aids _____ 102-103 _____ 104-105		Special equipment or aids _____ 17-18 _____ 19-20	
(4) 72 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age Ask 6d for next ADL with "Yes" in 1 3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.		(5) 89 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age Ask 6d for next ADL with "Yes" in 1 3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.		(6) 106 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY 2 <input type="checkbox"/> Old age Ask 6d for next ADL with "Yes" in 1 3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.		(7) 21 1 <input type="checkbox"/> 0-3 month Inj/Op ONLY } (Next page) 2 <input type="checkbox"/> Old age 3 <input type="checkbox"/> _____ Condition - Enter in ADL box on Condition Summary Chart, THEN ask 6d for next ADL with "Yes" in 1.	
FOOTNOTES							

Section R1. ACTIVITIES OF DAILY LIVING (ADL'S), Continued

<p>7a. Do you have difficulty controlling your bowels?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (7c)</p>	<p>22</p>
<p>b. How frequently do you have this difficulty – daily, several times a week, once a week, or less than once a week?</p>	<p><input type="checkbox"/> Daily <input type="checkbox"/> Several times a week <input type="checkbox"/> Once a week <input type="checkbox"/> Less than once a week <input type="checkbox"/> DK</p>	<p>23</p>
<p>c. Do you have a colostomy or a device to help control bowel movements?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (8)</p>	<p>24</p>
<p>d. Do you need help from another person in taking care of this device?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>25</p>
<p>8a. Do you have difficulty controlling urination?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (8c)</p>	<p>26</p>
<p>b. How frequently do you have this difficulty – daily, several times a week, once a week, or less than once a week?</p>	<p><input type="checkbox"/> Daily <input type="checkbox"/> Several times a week <input type="checkbox"/> Once a week <input type="checkbox"/> Less than once a week <input type="checkbox"/> DK</p>	<p>27</p>
<p>c. Do you have a urinary catheter or a device to help control urination?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (R1)</p>	<p>28</p>
<p>d. Do you need help from another person in taking care of this device?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>29</p>
<p>R1 <i>Mark first appropriate box</i></p>	<p><input type="checkbox"/> Respondent is a proxy <input type="checkbox"/> Sample person has only been seen in a bed or chair <input type="checkbox"/> Telephone interview <input type="checkbox"/> All other (Next page)</p>	<p>30 (9)</p>
<p><i>Mark if known</i></p> <p>9. Because of a health or physical problem, do you usually –</p>	<p><input type="checkbox"/> Yes (10) <input type="checkbox"/> No</p>	<p>31</p>
<p>a. Stay in bed all or most of the time?</p>	<p><input type="checkbox"/> Yes (10) <input type="checkbox"/> No (Next page)</p>	<p>32</p>
<p>10a. What (other) condition causes you to stay in [bed/a chair]?</p> <p><i>Ask if injury or operation: When did [the (injury) occur? / you have the operation?] Enter injury if over 3 months ago.</i></p> <p><i>Ask or reask 10b, if 0–3 months injury or operation.</i></p> <p><i>Ask if operation over 3 months ago: For what condition did you have the operation? Enter condition.</i></p>	<p><input type="checkbox"/> Old age (10c)</p>	
<p>b. Besides (condition), is there any other condition which causes this?</p>	<p><input type="checkbox"/> Yes (Reask 10a and b) <input type="checkbox"/> No (10d)</p>	
<p>c. Is this caused by any (other) specific condition?</p>	<p><input type="checkbox"/> Yes (Reask 10a and b) <input type="checkbox"/> No</p>	
<p><i>Ask if multiple conditions, including old age, are listed in 10a. Otherwise, mark appropriate box or transcribe the only listed condition.</i></p> <p>d. Which of these conditions, that is (read conditions in 10a) would you say is the MAIN cause of your staying in [bed/a chair] all or most of the time?</p>	<p><input type="checkbox"/> 0–3 month Inj/Op ONLY } (Next page) <input type="checkbox"/> Old age <input type="checkbox"/> _____</p> <p><i>Condition – Enter "9" in ADL box on Condition Summary Chart, THEN next page.</i></p>	<p>33</p>

Section R2. INCIDENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

Read to respondent — Now I will ask about some other activities. Tell me about doing them by yourself.

<p>11. Because of a health or physical problem, do you have ANY difficulty —</p> <p>Ask if "Doesn't do":</p> <p>Is this because of a HEALTH or PHYSICAL problem?</p> <p>If "Yes," mark box 1; if "No," mark box 3.</p>	<p align="center">(1) 34</p> <p>Preparing your own meals?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p>	<p align="center">(2) 46</p> <p>Shopping for personal items, (such as toilet items or medicines)?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Doesn't do for other reason</p>												
<p>Ask 12–14 for each IADL marked "Yes" in 11.</p>														
<p>12. By yourself, how much difficulty do you have (IADL), some, a lot, or are you unable to do it?</p>	<p align="center">35</p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p>	<p align="center">47</p> <p>1 <input type="checkbox"/> Some</p> <p>2 <input type="checkbox"/> A lot</p> <p>3 <input type="checkbox"/> Unable</p>												
<p>13. Do you receive help from another person in (IADL)?</p>	<p align="center">36</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)</p>	<p align="center">48</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)</p>												
<p>14a. Who gives this help?</p> <p>Anyone else?</p> <p>----- Mark the S/C/P box without asking if ONLY help is from spouse/children/parents. THEN 12 for next IADL with "Yes" in 11.</p> <p>b. Is this help paid for?</p> <p>Ask if necessary: Which helpers are paid?</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"> <p>Source of help 14a.</p> <p align="center">37–40</p> </td> <td style="width:50%; text-align: center;"> <p>Paid 14b.</p> <p align="center">41–44</p> </td> </tr> <tr> <td> <p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> <td> <p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> </tr> <tr> <td> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> <td> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> </tr> </table>	<p>Source of help 14a.</p> <p align="center">37–40</p>	<p>Paid 14b.</p> <p align="center">41–44</p>	<p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;"> <p>Source of help 14a.</p> <p align="center">49–52</p> </td> <td style="width:50%; text-align: center;"> <p>Paid 14b.</p> <p align="center">53–56</p> </td> </tr> <tr> <td> <p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> <td> <p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> </tr> <tr> <td> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> <td> <p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </td> </tr> </table>	<p>Source of help 14a.</p> <p align="center">49–52</p>	<p>Paid 14b.</p> <p align="center">53–56</p>	<p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>HH member 0 <input type="checkbox"/> S/C/P</p> <p>1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>	<p>Non-HH member</p> <p>3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
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<p>Ask 15 if any IADL marked "Yes" in 11.</p> <p>15a. What (other) condition causes the trouble in (read IADL(s))?</p> <p>Ask if injury or operation:</p> <p>When did (the (injury) occur? / you have the operation?)</p> <p>Enter injury if over 3 months ago.</p> <p>Ask or reask 15b, if 0–3 months injury or operation.</p> <p>Ask if operation over 3 months ago:</p> <p>For what condition did you have the operation?</p> <p>Enter condition.</p>	<p><input type="checkbox"/> Old age (15c)</p>													
<p>b. Besides (condition), is there any other condition which causes the trouble in (read IADL(s))?</p>	<p><input type="checkbox"/> Yes (Reask 15a and b)</p> <p><input type="checkbox"/> No (15d)</p>													
<p>c. Is the trouble in (read IADL(s)) caused by any (other) specific condition?</p>	<p><input type="checkbox"/> Yes (Reask 15a and b)</p> <p><input type="checkbox"/> No</p>													
<p>If multiple conditions, including old age, are listed in 15a, ask 15d for each IADL with a "Yes" in 11. Otherwise, mark appropriate box or transcribe the only listed condition.</p> <p>d. Which of these conditions, that is (read conditions in 15a) would you say is the MAIN cause of the trouble in (IADL)?</p>	<p align="center">(1) 45</p> <p>1 <input type="checkbox"/> 0–3 month Inj/ Op ONLY } 2 <input type="checkbox"/> Old age } Ask 15d for next IADL with "Yes" in 11</p>	<p align="center">(2) 57</p> <p>1 <input type="checkbox"/> 0–3 month Inj/ Op ONLY } 2 <input type="checkbox"/> Old age } Ask 15d for next IADL with "Yes" in 11</p>												
<p>Condition — Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.</p>														
<p>Condition — Enter in IADL box on Condition Summary Chart, THEN ask 15d for next IADL with "Yes" in 11.</p>														

FOOTNOTES

Section R2. INCIDENTAL ACTIVITIES OF DAILY LIVING (IADL'S), Continued

(3) 58		(4) 70		(5) 82		(6) 94	
Managing your money, (such as keeping track of expenses or paying bills)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		<i>Reask 11</i> Using the telephone? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Doing heavy housework, (like scrubbing floors, or washing windows)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason		Doing light housework, (like doing dishes, straightening up, or light cleaning)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Doesn't do for other reason	
59		71		83		95	
1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable		1 <input type="checkbox"/> Some 2 <input type="checkbox"/> A lot 3 <input type="checkbox"/> Unable	
60		72		84		96	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (12 for next IADL with "Yes" in 11)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (15)	
Source of help 14a. Paid 14b.		Source of help 14a. Paid 14b.		Source of help 14a. Paid 14b.		Source of help 14a. Paid 14b.	
61-64		65-68		69-72		73-76	
HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		HH member 0 <input type="checkbox"/> S/C/P 1 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Non-HH member 3 <input type="checkbox"/> Relative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4 <input type="checkbox"/> Nonrelative 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
(3) 69		(4) 81		(5) 93		(6) 105	
1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY 2 <input type="checkbox"/> Old age Ask 15d for next IADL with "Yes" in 11 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart. THEN ask 15d for next IADL with "Yes" in 11.		1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY 2 <input type="checkbox"/> Old age Ask 15d for next IADL with "Yes" in 11 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart. THEN ask 15d for next IADL with "Yes" in 11.		1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY 2 <input type="checkbox"/> Old age Ask 15d for next IADL with "Yes" in 11 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart. THEN ask 15d for next IADL with "Yes" in 11.		1 <input type="checkbox"/> 0-3 month Inj/ Op ONLY } Next page 2 <input type="checkbox"/> Old age } 3 <input type="checkbox"/> _____ Condition - Enter in IADL box on Condition Summary Chart. THEN next page	
FOOTNOTES							

Section S. NURSING HOME STAY, HELP WITH CARE, AND HOSPICE

1a. Have you ever been a resident or patient in a nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK } (S2)	5										
b. How many DIFFERENT TIMES have you been a resident or patient in a nursing home?	_____ Number of times	6-7										
c. When were you admitted (the FIRST time)?	_____ 19 _____ Month Year	8-11										
d. When were you discharged (the LAST time)?	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Month</td> <td style="padding: 2px;">Year</td> </tr> <tr> <td style="padding: 2px;"> </td> <td style="padding: 2px;">19</td> </tr> </table>	Month	Year		19	12-15						
Month	Year											
	19											
e. How long were you in the nursing home (the LAST time)?	<input type="checkbox"/> Less than 1 month _____ Number of months	16-17										
S1	<i>Refer to 1d</i>	<input type="checkbox"/> Date discharged is since the 12-month reference date (1f) <input type="checkbox"/> All other (S2)	18									
1f.	How many weeks in the past 12 months, that is, since (12 month date) a year ago, were you in a nursing home?	<input type="checkbox"/> Less than 1 week _____ Number of weeks	19-20									
S2	<i>Refer to age</i>	<input type="checkbox"/> Sample person is 55-64 (2) <input type="checkbox"/> Sample person is 65 or older (1g)	21									
1g.	Are you now on a waiting list to go into a nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	22									
2a.	Is there a friend, relative, or neighbor who would take care of you for a few DAYS, if necessary? (Include the people you live with.) <i>Mark one box only.</i>	Yes - Who is this person? <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width: 30%;">HH member</td> <td style="width: 10%; text-align: center;">OR</td> <td style="width: 60%;">Non-HH member</td> </tr> <tr> <td><input type="checkbox"/> Relative</td> <td></td> <td><input type="checkbox"/> Relative</td> </tr> <tr> <td><input type="checkbox"/> Nonrelative</td> <td></td> <td><input type="checkbox"/> Nonrelative</td> </tr> </table>	HH member	OR	Non-HH member	<input type="checkbox"/> Relative		<input type="checkbox"/> Relative	<input type="checkbox"/> Nonrelative		<input type="checkbox"/> Nonrelative	23
HH member	OR	Non-HH member										
<input type="checkbox"/> Relative		<input type="checkbox"/> Relative										
<input type="checkbox"/> Nonrelative		<input type="checkbox"/> Nonrelative										
b.	Is there a friend, relative, or neighbor who would take care of you for a few WEEKS, if necessary? (Include the people you live with.) <i>Mark one box only.</i>	Yes - Who is this person? <input type="checkbox"/> No <table style="width:100%; border: none;"> <tr> <td style="width: 30%;">HH member</td> <td style="width: 10%; text-align: center;">OR</td> <td style="width: 60%;">Non-HH member</td> </tr> <tr> <td><input type="checkbox"/> Relative</td> <td></td> <td><input type="checkbox"/> Relative</td> </tr> <tr> <td><input type="checkbox"/> Nonrelative</td> <td></td> <td><input type="checkbox"/> Nonrelative</td> </tr> </table>	HH member	OR	Non-HH member	<input type="checkbox"/> Relative		<input type="checkbox"/> Relative	<input type="checkbox"/> Nonrelative		<input type="checkbox"/> Nonrelative	24
HH member	OR	Non-HH member										
<input type="checkbox"/> Relative		<input type="checkbox"/> Relative										
<input type="checkbox"/> Nonrelative		<input type="checkbox"/> Nonrelative										
3a.	<i>Skip to Section T if a proxy</i> Are you familiar with the term "HOSPICE," that is, a service for the terminally ill?	<input type="checkbox"/> Yes <input type="checkbox"/> No/DK (Section T)	25									
b.	Is there a hospice or an in-home hospice service in the [metropolitan area/county] that you could use if you needed one?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	26									

FOOTNOTES

Section T. HEALTH OPINIONS		
T1	Respondent	1 <input type="checkbox"/> Self response (1) 2 <input type="checkbox"/> Proxy (T2) 27
Read to respondent — Now I'd like to ask your personal opinions about health related matters.		
1.	How good a job do you feel you are doing in TAKING CARE of your health? Would you say excellent, very good, good, fair, or poor?	1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor 28
2.	Compared with 1 year ago, would you say that your health is now better, worse, or about the same as it was then?	1 <input type="checkbox"/> Better 2 <input type="checkbox"/> Worse 3 <input type="checkbox"/> Same 29
3.	During the PAST YEAR, has your overall health caused you a great deal of worry, some worry, hardly any worry, or no worry at all?	1 <input type="checkbox"/> A great deal of worry 2 <input type="checkbox"/> Some worry 3 <input type="checkbox"/> Hardly any worry 4 <input type="checkbox"/> No worry at all 30
4a.	Compared to other people your age, would you say you are physically more active, less active, or about as active?	1 <input type="checkbox"/> More active 2 <input type="checkbox"/> Less active 3 <input type="checkbox"/> About as active (5) 31
b.	Is that [a lot more or a little more active/a lot less or a little less active]?	1 <input type="checkbox"/> Lot more 2 <input type="checkbox"/> Little more 3 <input type="checkbox"/> Lot less 4 <input type="checkbox"/> Little less 32
5a.	Compared to your own level of physical activity 1 year ago, would you say you are now more active, less active, or about the same as you were then?	1 <input type="checkbox"/> More active 2 <input type="checkbox"/> Less active 3 <input type="checkbox"/> About the same (6) 33
b.	Is that [a lot more or a little more active/a lot less or a little less active]?	1 <input type="checkbox"/> Lot more 2 <input type="checkbox"/> Little more 3 <input type="checkbox"/> Lot less 4 <input type="checkbox"/> Little less 34
6.	How much control do you think YOU have over your future health? Would you say you have a great deal of control, some, very little, or none at all?	1 <input type="checkbox"/> A great deal of control 2 <input type="checkbox"/> Some control 3 <input type="checkbox"/> Very little control 4 <input type="checkbox"/> None at all 35
7.	Do you feel that you get as much exercise as you need, or less than you need?	1 <input type="checkbox"/> As much as needed 2 <input type="checkbox"/> Less than needed 36
8.	Do you follow a REGULAR routine of physical exercise?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 37
9.	How often do you walk a mile or more at a time, without resting? <i>(Note: One mile equals 8–12 blocks.)</i> Probe if necessary: About how many days a week is that?	1 <input type="checkbox"/> Every day 2 <input type="checkbox"/> 4–6 days a week 3 <input type="checkbox"/> 2–3 days a week 4 <input type="checkbox"/> 1 day a week 5 <input type="checkbox"/> Less than 1 day a week 6 <input type="checkbox"/> Never 38
10a.	People find that they sometimes have more trouble remembering things as they get older. In the PAST YEAR, about how often did you have trouble remembering things — frequently, sometimes, rarely, or never?	1 <input type="checkbox"/> Frequently 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never (11) 39
b.	Compared with a year ago, does this now happen more often, less often, or about the same?	1 <input type="checkbox"/> More often 2 <input type="checkbox"/> Less often 3 <input type="checkbox"/> About the same 40
11a.	People find that they sometimes get confused as they get older. In the PAST YEAR, about how often did you get confused — frequently, sometimes, rarely, or never?	1 <input type="checkbox"/> Frequently 2 <input type="checkbox"/> Sometimes 3 <input type="checkbox"/> Rarely 4 <input type="checkbox"/> Never (T2) 41
b.	Compared with a year ago, does this now happen more often, less often, or about the same?	1 <input type="checkbox"/> More often 2 <input type="checkbox"/> Less often 3 <input type="checkbox"/> About the same 42
T2	Type of interview	1 <input type="checkbox"/> Self-personal 2 <input type="checkbox"/> Self-telephone 3 <input type="checkbox"/> Proxy personal 4 <input type="checkbox"/> Proxy telephone } Go to Condition Summary Chart (T3) 43
T3	a. Proxy Reason	1 <input type="checkbox"/> Sample person temporarily absent 2 <input type="checkbox"/> Sample person mentally/physically incapable of responding (Explain) 3 <input type="checkbox"/> Other (Explain) 44
	b. Enter person number of proxy respondent, or mark box.	00 <input type="checkbox"/> Non-HH member ____ Proxy Person No. } Go to Condition Summary Chart 45–46

