

FORM **ACS-2 (1994)**  
(6-1-94)

U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
ACTING AS COLLECTING AGENT FOR THE  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL  
NATIONAL CENTER FOR HEALTH STATISTICS

**1994 ACCESS TO CARE SURVEY**

**NOTICE** - Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to average 25 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA; Humphrey Building, Room 721-B, 200 Independence Avenue, SW; Washington, DC 20201; and to the Office of Management and Budget, Paperwork Reduction Project (0920-0346) Washington, DC 20503.

**PROXY STATUS**

Mark (X) the appropriate proxy status for the sample person.

- 1  Self-respondent      2  Proxy-respondent for child      3  Proxy-respondent for adult

**RECORD OF INTERVIEW**

Field Representative's name

Code

1. Beginning time

- 1  a.m.  
2  p.m.

2. Ending time

- 1  a.m.  
2  p.m.

3. Length of interview (Minutes)

4. Date completed

Month	Day	Year

**NONINTERVIEW REASON**

1  Refused - Explain

2  Temporarily absent - Explain (e.g., unavailable through closeout)

3  Ill, hospitalized - Explain

4  No knowledgeable proxy - Explain

- 5  Unable to contact  
6  Sample person deceased  
7  Sample person institutionalized  
8  Other - Explain

Notes

**Section A - GENERAL INFORMATION**

<b>A1. Would you say (Name's/your) health, in general, is excellent, very good, good, fair, or poor?</b>	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
<b>A2. Since (Date) a year ago, (was/were) (Name/you) a patient in a hospital overnight or longer?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - GO to A4
<b>A3. How many different times did (Name/you) stay in a hospital overnight or longer since (Date) a year ago?</b>	_____ Times
<b>A4. During the past 12 months, (that is, since (Date) a year ago,) about how many times did (Name/you) see or talk to a medical doctor or assistant? (Do not count doctors seen while an overnight patient in a hospital.)</b>	_____ Times

<b>CHECK ITEM A5</b>	Refer to A5. For each "Yes" in A5, ask A6-A8. If all of the responses in A5 are "No", GO to A9.
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<b>A5. In the past 12 months, (has/have) (Name/you) seen a professional for any of the following kinds of treatment? (IF ASKED: A PROFESSIONAL IS SOMEONE WHO PROVIDES CARE OR GIVES ADVICE AND IS PAID FOR HIS OR HER SERVICES.)</b>  Mark (X) all that apply.	<b>A6. You said that (Name/you) had (service from A5 where response is "Yes") in the past twelve months. Was this for a specific problem or condition, or not?</b>	<b>A7. What was the problem or condition? (RECORD VERBATIM)</b>	<b>A8. (Has/Have) (Name/you) also seen a medical doctor about this condition?</b>
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Specific condition 2 <input type="checkbox"/> Not for specific condition (GO to next service)	_____ _____ _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Provider was a medical doctor
<b>a. chiropractic services?</b>	1 <input type="checkbox"/> Specific condition 2 <input type="checkbox"/> Not for specific condition (GO to next service)	_____ _____ _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Provider was a medical doctor
<b>b. relaxation techniques?</b>	1 <input type="checkbox"/> Specific condition 2 <input type="checkbox"/> Not for specific condition (GO to next service)	_____ _____ _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Provider was a medical doctor
<b>c. therapeutic massage?</b>	1 <input type="checkbox"/> Specific condition 2 <input type="checkbox"/> Not for specific condition (GO to next service)	_____ _____ _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Provider was a medical doctor
<b>d. acupuncture?</b>	1 <input type="checkbox"/> Specific condition 2 <input type="checkbox"/> Not for specific condition (GO to A9)	_____ _____ _____	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Provider was a medical doctor

The next few questions are about (Name's/your) health care coverage.	
<b>A9. Medicare is a government health insurance program for disabled persons and for persons 65 years of age or older. (Is/are) (Name/you) covered by Medicare?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

<b>A10. (Is/are) (Name/you) covered by CHAMPUS or CHAMPVA?</b>  Read if necessary: CHAMPUS is a program of medical care for dependents of active or retired military personnel. CHAMPVA is medical insurance for dependents or survivors of disabled veterans.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
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**Section B - USUAL SOURCE OF CARE**

<p><b>B1.</b> Is there <b>ONE</b> particular person or place that (Name/you) usually (goes/go) to when (he/she/you) (is/are) sick or need advice about health?</p>	<p>1 <input type="checkbox"/> Yes - GO to B7                  2 <input type="checkbox"/> No                  3 <input type="checkbox"/> THERE IS MORE THAN ONE</p>
<p><b>B2.</b> People have many different reasons for not having a usual source of medical care. Some people have two or more regular doctors or places, and where they go depends on what's wrong. Is that a reason (Name/you) (doesn't/don't) have a usual source of medical care?</p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No - GO to B4</p>
<p><b>B3.</b> Would you say that is the main reason?</p>	<p>1 <input type="checkbox"/> Yes - GO to B6                  2 <input type="checkbox"/> No</p>
<p><b>B4.</b> I am going to read some other reasons people have given for not having a usual source of medical care. For each one, please tell me whether that is a reason in (Name's/your) case. (First, next.)</p> <p><b>a.</b> There is no reason to have a usual source of care because (Name/I) seldom or never (gets/get) sick. Is that a reason (Name/you) (doesn't/don't) have a usual source of medical care?</p> <p><b>b.</b> (Name/I) recently moved into the area. Is that a reason (Name/you) (doesn't/don't) have a usual source of medical care?</p> <p><b>c.</b> (Name's/my) usual source of medical care in this area is no longer available. Is that a reason (Name/you) (does not/do not) have a usual source of medical care?</p> <p><b>c1.</b> Why is (Name's/your) usual source of medical care no longer available?</p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No</p> <p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No - GO to B5</p> <p>1 <input type="checkbox"/> Previous doctor retired                  2 <input type="checkbox"/> Previous doctor died                  3 <input type="checkbox"/> Previous doctor moved                  4 <input type="checkbox"/> (Name/You) moved                  5 <input type="checkbox"/> Previous doctor/place too far away                  88 <input type="checkbox"/> Other - Specify <input checked="" type="checkbox"/> _____                  _____                  _____</p>
<p><b>B5.</b> Is there any other reason (he/she/you) (does NOT/do NOT) have a usual source of care?</p>	<p>1 <input type="checkbox"/> Yes - Specify <input checked="" type="checkbox"/> - GO to C1                  _____                  _____                  _____                  _____</p> <p>2 <input type="checkbox"/> No - GO to C1</p>
<p><b>B6.</b> Is there one of these places that (Name/you) (goes/go) to most often when (Name/you) (is/are) sick or needs advice about (his/her/your) health?</p>	<p>1 <input type="checkbox"/> Yes                  2 <input type="checkbox"/> No                  99 <input type="checkbox"/> Don't know } GO to D1</p>
<p><b>B7.</b> What kind of a place is it - a clinic, a health care center, a hospital, a doctor's office, or some other place?</p>	<p>1 <input type="checkbox"/> Doctor's Office or Private Clinic                  2 <input type="checkbox"/> Company or School Health Clinic/Center                  3 <input type="checkbox"/> Community/Neighborhood or Migrant/Rural Health Center/Clinic                  4 <input type="checkbox"/> County/City Clinic or County Hospital Outpatient Clinic (Public Clinic)                  5 <input type="checkbox"/> Private/Other Hospital Outpatient Clinic                  6 <input type="checkbox"/> Hospital Emergency Room                  7 <input type="checkbox"/> HMO (Health Maintenance Organization)/Other Prepaid Group                  8 <input type="checkbox"/> Psychiatric Hospital or Clinic                  9 <input type="checkbox"/> VA Hospital or Clinic                  88 <input type="checkbox"/> Some Other Place - Specify <input checked="" type="checkbox"/> _____                  _____                  _____</p>

**Section B - USUAL SOURCE OF CARE - Continued**

<b>B8. Is there a particular person (Name/you) usually (sees/see) when (he/she/you) (goes/go) there?</b>	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No - GO to B13
<b>B9. Is that person a doctor, a nurse, or some other type of health professional?</b> <i>Probe for type of health professional.</i>	<input type="checkbox"/> 1 Doctor <input type="checkbox"/> 2 Nurse <input type="checkbox"/> 3 Nurse Practitioner <input type="checkbox"/> 4 Physician's assistant <input type="checkbox"/> 5 Chiropractor <input type="checkbox"/> 88 Other - Specify <i>z</i> _____ <input type="checkbox"/> 99 Don't know
<b>B10. Is the doctor a general or family practitioner who treats a variety of illnesses and gives preventive care or is he or she a specialist who mainly treats just one type of health problem?</b>	<input type="checkbox"/> 1 General Practitioner <input type="checkbox"/> 2 Obstetrician/Gynecologist (OB/GYN) <input type="checkbox"/> 3 Other specialist <input type="checkbox"/> 99 Don't know - GO to B12a
<b>B11. What is the doctor's specialty?</b>	<input type="checkbox"/> 1 Internist/Internal Medicine <input type="checkbox"/> 2 Pediatrics <input type="checkbox"/> 3 General Surgery <input type="checkbox"/> 88 Other - Specify <i>z</i> _____
<b>B12a. Is this person male or female?</b>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female
<b>b. What is this person's race?</b>	<input type="checkbox"/> 1 Black <input type="checkbox"/> 2 White <input type="checkbox"/> 3 Asian/Pacific Islander <input type="checkbox"/> 4 American Indian/Alaska Native <input type="checkbox"/> 88 Other - Specify <i>z</i> _____
<b>c. Is this person of Hispanic origin?</b>	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 99 Don't know
<b>d. Does (he/she) speak (Name's/your) primary language?</b>	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 99 Don't know
<b>B13. How long (has/have) (Name/you) been (seeing this person/going to this place) for medical care?</b>	_____ Years OR _____ Months <input type="checkbox"/> 77 All (Name's/your) life
<b>B14a. How (does/do) (Name/you) usually get there - by walking, driving, being driven by someone else, by taxi, by public transportation, or some other way?</b>	<input type="checkbox"/> 1 Walking <input type="checkbox"/> 2 Driving <input type="checkbox"/> 3 Being driven by someone else <input type="checkbox"/> 4 Taxi <input type="checkbox"/> 5 Other public transportation <input type="checkbox"/> 6 Ambulance <input type="checkbox"/> 88 Other - Specify <i>z</i> - GO to B14c _____
<b>b. How much does it usually cost to get there (one way)?</b>	\$ _____ Cost
<b>c. About how long does it usually take (Name/you) to get there?</b>	_____ Minutes OR _____ Hours

**Section B - USUAL SOURCE OF CARE - Continued**

<b>B15. When was the last time (Name/you) went to this (person/place) for medical care?</b>	1 <input type="checkbox"/> Less than 6 months ago 2 <input type="checkbox"/> At least 6 months, but less than one year ago 3 <input type="checkbox"/> At least one year, but less than three years ago 4 <input type="checkbox"/> Three or more years ago 5 <input type="checkbox"/> Never been there - GO to CHECK ITEM B15
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<b>CHECK ITEM B15</b>	If the response to B1 is "Yes", ask "You said that you have never been to a particular person or place for medical care; however, earlier you indicated that you had been to a particular person or place when (Name/you (were/was) sick or needed advice about health. Is this correct?" If the response is "Yes" continue with B16a, if the response is "No" reask B15.
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<b>B16a. About how long (does/do) (Name/you) usually have to wait before getting an appointment to see a medical person (with/at) this (person/place)?</b>	_____ Days  OR  _____ Weeks  97 <input type="checkbox"/> No appointment needed
<b>b. About how long (does/do) (Name/you) usually have to wait in the waiting room before seeing a medical person when (he/she/you) (goes/go) to this (person/place)?</b>	_____ Minutes  OR  _____ Hours

<b>CHECK ITEM B7</b>	Refer to B7. If the response to B7 is 6 (hospital emergency room), GO to CHECK ITEM B13, else GO to D1a1.
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<b>CHECK ITEM B13</b>	Refer to B13. If the response to B13 is 77 (All (Name/your) life ), GO to B19, else GO to B17.
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<b>B17. You said that (Name's/your) usual source of care is a hospital emergency room. In the past 12 months did (Name/you) go to a different kind of place, like a clinic or doctor's office, when (he/she/you) (was/were) sick or needed advice about (his/her/your) health?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - GO to B19
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<b>B18. [You said that (Name's/your) usual source of care is a hospital emergency room.] Did a doctor at the emergency room ever tell (Name/you) (he/she/you) should go somewhere else for medical care?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
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<b>CHECK ITEM B17</b>	Refer to B17. If the response to B17 is "Yes", GO to D1a1.
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<b>B19. (Has/Have) (Name/you) tried to find a different place to get professional medical care?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - GO to B21
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<b>B20. (Has/Have) (Name/you) been able to find a different place?</b>	1 <input type="checkbox"/> Yes - GO to D1a1 2 <input type="checkbox"/> No
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<b>B21. Why not?</b>	1 <input type="checkbox"/> No health insurance 2 <input type="checkbox"/> Can't find an affordable place 3 <input type="checkbox"/> Can't find a place that takes Medicaid 4 <input type="checkbox"/> Language problem 5 <input type="checkbox"/> Transportation problem 88 <input type="checkbox"/> Other - Specify <u>      </u> _____ _____
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} GO to D1a1

Notes
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**Section C - NO USUAL SOURCE**

**C1. At ANY time in the past 12 months did (he/she/you) have a place that (he/she/you) went to or called when (he/she/you) (was/were) sick or needed advice about health?**

- 1  Yes
- 2  No - GO to D1a1

**C2. What kind of a place was it — a clinic, a health center, a hospital, a doctor's office, or some other place?**

- 1  Doctor's office or private clinic
- 2  Company or school health clinic/Center
- 3  Community/Neighborhood or migrant/Rural health center/Clinic
- 4  County/City clinic or county hospital outpatient clinic (public clinic)
- 5  Private/Other hospital outpatient clinic
- 6  Hospital emergency room
- 7  HMO (Health Maintenance Organization)/Other prepaid group
- 8  Psychiatric hospital
- 88  Some other place - Specify

**C3. If (he/she/you) needed medical care now, would (he/she/you) use (Place in C2)?**

- 1  Yes - GO to D1a1
- 2  No

**C4. What is the main reason (Name/you) would not use that place for medical care now? (RECORD VERBATIM)**

\_\_\_\_\_

\_\_\_\_\_

Notes



**Section D - UNMET NEEDS - Continued**

**D2a2. The LAST TIME (Name/you) did not try to get the medical care (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't try to get care?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason - *Specify*

\_\_\_\_\_  
\_\_\_\_\_

**CHECK ITEM D3**

*Refer to D1b2.*

- 1  D1b2 is "Yes" - GO to D2b1
- 2  D1b2 is "No" - GO to D2b2
- 3  Other - GO to CHECK ITEM D4

**D2b1. The LAST TIME (Name/you) did not get the dental care (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't get care?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason - *Specify*

GO to CHECK ITEM D4

\_\_\_\_\_  
\_\_\_\_\_

**D2b2. The LAST TIME (Name/you) did not try to get the dental care (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't try to get care?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason - *Specify*

\_\_\_\_\_  
\_\_\_\_\_

**CHECK ITEM D4**

*Refer to D1c2.*

- 1  D1c2 is "Yes" - GO to D2c1
- 2  D1c2 is "No" - GO to D2c2
- 3  Other - GO to CHECK ITEM D5

Notes

**Section D – UNMET NEEDS – Continued**

**D2c1. The LAST TIME (Name/you) did not get the prescribed medicine (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't get the medicine?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason – *Specify* z

GO to  
CHECK  
ITEM D5

**D2c2. The LAST TIME (Name/you) did not try to get the prescribed medicine (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't try to get the medicine?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason – *Specify* z

**CHECK  
ITEM D5**

*Refer to D1d2.*

- 1  D1d2 is "Yes" – GO to D2d1
- 2  D1d2 is "No" – GO to D2d2
- 3  Other – GO to CHECK ITEM D6

**D2d1. The LAST TIME (Name/you) did not get the eyeglasses (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't get the eyeglasses?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason – *Specify* z

GO to  
CHECK  
ITEM D6

Notes

**Section D – UNMET NEEDS – Continued**

**D2d2. The LAST TIME (Name/you) did not try to get the eyeglasses (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't try to get the eyeglasses?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason – *Specify*

\_\_\_\_\_

\_\_\_\_\_

**CHECK ITEM D6**

*Refer to D1e2.*

- 1  D1e2 is "Yes" – GO to D2e1
- 2  D1e2 is "No" – GO to D2e2
- 3  Other – GO to CHECK ITEM D7(1)

**D2e1. The LAST TIME (Name/you) did not get the mental health care or counseling (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't get care?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason – *Specify*

} GO to CHECK ITEM D7(1)

\_\_\_\_\_

\_\_\_\_\_

**D2e2. The LAST TIME (Name/you) did not try to get the mental health care or counseling (he/she/you) wanted, what was the MAIN reason (he/she/you) didn't try to get care?**

- 1  Could not afford it
- 2  No insurance
- 3  Doctor did not accept Medicaid/Insurance
- 4  Not serious enough
- 5  Wait too long in clinic/office
- 6  Difficulty in getting appointment
- 7  Doesn't like/trust/believe in doctors
- 8  No doctor available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speak a different language
- 13  Health of another family member
- 88  Other reason – *Specify*

\_\_\_\_\_

\_\_\_\_\_

**CHECK ITEM D7(1)**

*Refer to D1a1.*

- 1  D1a1 is "Yes" – GO to D3
- 2  D1a1 is "No" – GO to CHECK ITEM D7(2)

**CHECK ITEM D7(2)**

*Refer to D1a3.*

- 1  D1a3 is "Yes" – GO to D3
- 2  D1a3 is "No" – GO to CHECK ITEM D8

Notes



**Section D - UNMET NEEDS - Continued**

<b>D14. At that time, how serious did (Name/you) think it was? Was it —</b>	<input type="checkbox"/> Very serious, <input type="checkbox"/> Somewhat serious, <input type="checkbox"/> Not serious at all?
<b>D15. Did (he/she/you) cut down on things (he/she/you) usually (does/do) for longer than a day because of this problem?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>D16. (Was/were) (he/she/you) treated for this later?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No – GO to D19
<b>D17. How long after (he/she/you) tried to get dental care (was/were) (he/she/you) treated? Was it —</b>	<input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
<b>D18. Why (was/were) (he/she/you) finally able to get care? (RECORD VERBATIM)</b>	
<b>D19. Do you think (Name/you) would have been better off if (he/she/you) had gotten care (earlier)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>CHECK ITEM D9</b>	<i>Refer to D1c1.</i> <input type="checkbox"/> D1c1 is "Yes" – GO to D20 <input type="checkbox"/> D1c1 is "No" – GO to CHECK ITEM D10
<b>In the next few questions I will be asking you about (Name's/your) prescribed medicine.</b>	
<b>D20. (The last time) (Name/you) wanted a prescribed medicine but could not get it at that time, did (Name/you) actually have a prescription from a doctor for the medicine (he/she/you) could not get when it was needed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>D21. What condition or problem was it for? (RECORD VERBATIM)</b>	
<b>D22. At that time, how serious did (Name/you) think it was? Was it —</b>	<input type="checkbox"/> Very serious, <input type="checkbox"/> Somewhat serious, <input type="checkbox"/> Not serious at all?
<b>D23. Did (Name/you) get the medicine later?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No – GO to D26
<b>D24. How long after (he/she/you) tried to get it did (he/she/you) get the prescribed medicine? Was it —</b>	<input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
<b>D25. Why (was/were) (he/she/you) finally able to get the medicine? (RECORD VERBATIM)</b>	
<b>D26. Do you think (NAME/you) would have been better off if (he/she/you) had gotten the medicine (earlier)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>CHECK ITEM D10</b>	<i>Refer to D1d1.</i> <input type="checkbox"/> D1d1 is "Yes" – GO to D27 <input type="checkbox"/> D1d1 is "No" – GO to CHECK ITEM D11

**Section D – UNMET NEEDS – Continued**

<p><b>In the next few questions, I will be asking you about (Name's/your) need for eyeglasses.</b></p>		
<p><b>D27. (The last time) (Name/you) wanted eyeglasses but could not get them at that time, did a doctor or other health professional tell (Name/you) that (he/she/you) needed eyeglasses?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p><b>D28. At that time, how serious did (he/she/you) think it was? Was it —</b></p>		<p>1 <input type="checkbox"/> Very serious, 2 <input type="checkbox"/> Somewhat serious, 3 <input type="checkbox"/> Not serious at all?</p>
<p><b>D29. Did (he/she/you) get the eyeglasses later?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – GO to D32</p>
<p><b>D30. How long after (he/she/you) tried to get them did (he/she/you) get the eyeglasses? Was it —</b></p>		<p>1 <input type="checkbox"/> Weeks 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Years</p>
<p><b>D31. Why (was/were) (he/she/you) finally able to get the eyeglasses? (RECORD VERBATIM)</b></p> <hr/> <hr/>		
<p><b>D32. Do you think (Name/you) would have been better off if (he/she/you) had gotten the eyeglasses (earlier)?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p><b>CHECK ITEM D11</b></p>	<p><i>Refer to D1e1.</i></p>	<p>1 <input type="checkbox"/> D1e1 is "Yes" – GO to D33 2 <input type="checkbox"/> D1e1 is "No" – GO to E1</p>
<p><b>In the next few questions, I will be asking you about (Name's/your) mental health care.</b></p>		
<p><b>D33. (The last time) (Name/you) wanted mental health care or counseling but could not get it at that time, did a doctor or other mental health professional tell (Name/you) that (he/she/you) needed this mental health care or counseling?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p><b>D34. At that time, how serious did (he/she/you) think it was? Was it —</b></p>		<p>1 <input type="checkbox"/> Very serious, 2 <input type="checkbox"/> Somewhat serious, 3 <input type="checkbox"/> Not serious at all?</p>
<p><b>D35. Did (he/she/you) cut down on the things (he/she/you) usually (does/do) for longer than a day because of this problem?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p><b>D36. Did (he/she/you) get the mental health care or counseling (he/she/you) needed later?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – GO to D40</p>
<p><b>D37. How long after (he/she/you) tried to get care did (he/she/you) get care? Was it —</b></p>		<p>1 <input type="checkbox"/> Weeks 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Years</p>
<p><b>D38. Why (was/were) (he/she/you) finally able to get care? (RECORD VERBATIM)</b></p> <hr/> <hr/>		
<p><b>D39. Did (he/she/you) get the care at the first place (he/she/you) tried?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>
<p><b>D40. Do you think (Name/you) would have been better off if (he/she/you) had received care (earlier)?</b></p>		<p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>

### Section E – SICK LEAVE, GETTING TO THE DOCTOR

**In the next few questions, I will be asking you about (Name's/your) sick leave and questions about how and who goes with (Name/you) to the doctor.**

<b>CHECK ITEM E</b>	Refer to age on cover page.	<input type="checkbox"/> Age is 17 or younger – GO to E6 <input type="checkbox"/> Age is 18 or older – GO to E1
<b>E1.</b>	<b>(Does/Do) (Name/you) currently have a job for pay?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No – GO to E6
<b>E2.</b>	<b>(Is/Are) (Name/ you) self-employed, or (does/do) (he/she/you) work for someone else?</b>	<input type="checkbox"/> Self-employed – GO to E6 <input type="checkbox"/> Works for someone else <input type="checkbox"/> Both
<b>E3.</b>	<b>(Does/do) (Name/you) get paid time off from work when (he/she/you) (is/are) sick?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>E4.</b>	<b>(Does/do) (Name/you) get paid time off from work when (he/she/you) (has/have) to go to see a doctor?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>E5.</b>	<b>How would you describe (Name's/your) employer's reaction to (his/her/your) taking time off from work to go to the doctor — does it cause a lot of trouble or concern, some trouble or concern, a little trouble or concern, or no trouble or concern at all?</b>	<input type="checkbox"/> Lot of trouble/concern <input type="checkbox"/> Some trouble/concern <input type="checkbox"/> A little trouble/concern <input type="checkbox"/> No trouble/concern at all <input type="checkbox"/> EMPLOYER DOESN'T KNOW
<b>E6.</b>	<b>Does someone usually go with (Name/you) when (he/she/you) (goes/go) to the doctor?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No – GO to F1
<b>E7.</b>	<b>Who usually goes to the doctor with (Name/you)?</b>	<input type="checkbox"/> Spouse <input type="checkbox"/> Mother/Stepmother <input type="checkbox"/> Father/Stepfather <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Grandparent <input type="checkbox"/> Other relative <input type="checkbox"/> Non-relative
<b>E8.</b>	<b>Does (Person in E7) ever have to take time off from work to take (Name/you) to the doctor?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't work } GO to F1
<b>E9.</b>	<b>Is (Person in E7) self-employed, or does (he/she) work for someone else?</b>	<input type="checkbox"/> Self-employed – GO to F1 <input type="checkbox"/> Works for someone else <input type="checkbox"/> Both – GO to F1
<b>CHECK ITEM E1</b>	Refer to PROXY STATUS on cover page to determine type of proxy. If self-respondent, GO to E10a. If proxy for someone else in household (proxy-respondent) and they are the person in E7, GO to E10b, else GO to F1.	
<b>E10a.</b>	<b>Have you ever had to put off going to the doctor because (Person in E7) could not get time off from work?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No } GO to F1
	<b>b. Are you always able to take paid leave when you take time off from work to accompany (Name) to the doctor?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>E11.</b>	<b>How would you describe your employer's reaction to your taking time off from work to accompany (Name) to the doctor — does it cause a lot of trouble or concern, some trouble or concern, a little trouble or concern, or no trouble or concern at all?</b>	<input type="checkbox"/> Lot of trouble/concern <input type="checkbox"/> Some trouble/concern <input type="checkbox"/> A little trouble/concern <input type="checkbox"/> No trouble/concern at all <input type="checkbox"/> EMPLOYER DOESN'T KNOW
Notes		

**Section F – SYMPTOMS/RESPONSE**

**SYMPTOM 1**

**F2-INSTRUCTIONS**

*You will ask the series of questions F2 through F24, as appropriate, for the first three symptoms to which the respondent answers "Yes". However, ask ONLY item F2 as the follow-up for items n, o, and p. Also, if item n, o, or p is "Yes", DO NOT COUNT THIS ITEM AS ONE OF THE THREE FOLLOW-UPS.*

**ALL ITEMS F2 THROUGH F24 REFER TO THE SPECIFIC SYMPTOM MENTIONED IN THE LIST. THE QUESTIONS DO NOT REFER TO ANY UNDERLYING CONDITION WHICH MIGHT CAUSE THE SYMPTOMS.**

<b>F2.</b>	<b>You said that (Name/you) had had (symptom in F1a-x where response is "Yes") in the past three months. During that time, (have/has) (Name/you) seen a doctor, nurse, or other professional about this problem?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	<i>ASK F2n ONLY if F1n is "Yes".</i>	
<b>F2n.</b>	<b>You said that (Name/you) had had (symptom in F1n) in the past three months. During that time, (have/has) (Name/you) seen a doctor, nurse, or other professional about this problem?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	<i>ASK F2o ONLY if F1o is "Yes".</i>	
<b>F2o.</b>	<b>You said that (Name/you) had had (symptom in F1o) in the past three months. During that time, (have/has) (Name/you) seen a doctor, nurse, or other professional about this problem?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	<i>ASK F2p ONLY if F1p is "Yes".</i>	
<b>F2p.</b>	<b>You said that (Name/you) had had (symptom in F1p) in the past three months. During that time, (have/has) (Name/you) seen a doctor, nurse, or other professional about this problem?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
<b>F3.</b>	<b>Is this an old problem, or something new?</b>	1 <input type="checkbox"/> Old problem 2 <input type="checkbox"/> Something new
<b>F4.</b>	<b>Did (Name/you) see a doctor, nurse, or other professional for the same problem at any time in the preceding year?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
<b>CHECK ITEM F2</b>	<i>Refer to F2 and F3.</i>	1 <input type="checkbox"/> F2 is "Yes" and F3 is "Something new" – GO to F5 2 <input type="checkbox"/> F2 is "Yes" and F3 is "Old problem" – GO to F6 3 <input type="checkbox"/> F2 is "No" – GO to F7
<b>F5.</b>	<b>How soon did (Name/you) see a doctor, nurse, or other professional about this problem after it started? Was it —</b>	1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months
<b>F6.</b>	<b>How many times during the past three months (has/have) (Name/you) seen a doctor, nurse, or other professional about this problem?</b>	_____ Times (next symptom in F1a-x) <i>(GO to G1 once all symptoms are complete)</i>
<b>F7.</b>	<b>During the past three months, (has/have) (Name/you) talked to a doctor or nurse by telephone about this problem?</b>	1 <input type="checkbox"/> Yes – GO to CHECK ITEM F3 2 <input type="checkbox"/> No – GO to F16
<b>CHECK ITEM F3</b>	<i>Refer to F3.</i>	1 <input type="checkbox"/> F3 is "Something new" – GO to F8 2 <input type="checkbox"/> F3 is "Old problem" – GO to F9
<b>F8.</b>	<b>How soon did (Name/you) telephone a doctor or nurse about this problem after it started?</b>	1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Weeks 3 <input type="checkbox"/> Months
<b>F9.</b>	<b>How many times during the past three months (have/has) (Name/you) talked with a doctor or nurse about this problem?</b>	_____ Times
<b>F10.</b>	<b>Did (Name/you) think that (he/she/you) needed to see a medical person for treatment of this problem, rather than just talk to someone on the telephone, at any time in the past three months?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (Next symptom in F1a-x) (GO to G1 once symptoms are complete)

**Section F – SYMPTOMS/RESPONSE – Continued**

**F11. Why didn't (Name/you) actually see a doctor or nurse in the past three months about this problem?**

*Probe: "Any other reason?"*

*Mark (X) all that apply.*

- 1  Doctor said didn't need to be seen
- 2  Could not afford it/no insurance
- 3  Refused care because of lack of money or insurance
- 4  Provider did not accept Medicaid/insurance
- 5  Difficulty in getting appointment
- 6  Afraid/Embarrassed/Ashamed to go
- 7  Didn't think they could help
- 8  No provider available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speaks a different language
- 13  Health of another family member
- 88  Other reason – *Specify*  (RECORD VERBATIM)

**F12. (Was/were) (Name's/your) health affected in any way because (Name/you) did not receive medical care?**

- 1  Yes
- 2  No – GO to F14

**F13. How was (Name's/ your) health affected? (RECORD VERBATIM)**

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**F14. Did (Name/you) have any personal, household, or work problems because (he/she/you) did not receive medical care for this problem?**

- 1  Yes
- 2  No (Next symptom in F1a-x) (GO to G1 once symptoms are complete)

**F15. What were they? (RECORD VERBATIM)**

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*GO to next symptom in F1a-x, if no more symptoms, GO to G1*

**F16. At any time in the past three months, did (Name/you) think that (he/she/you) needed to contact a doctor or other medical person about this problem?**

- 1  Yes – GO to F18
- 2  No – GO to F17

**F17. Why did (Name/you) think that medical care was unnecessary? (RECORD VERBATIM)**

*Probe: Is there any other reason?*

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*GO to next symptom, if no more, GO to G1*

**F18. Did (Name/you) actually try to see a medical person about this problem?**

- 1  Yes
- 2  No – GO to F20

Notes

**Section F – SYMPTOMS/RESPONSE – Continued**

**F19. Why couldn't (Name/you) see a medical person?**

Probe: "Any other reason?"

Mark (X) all that apply.

- 1  Doctor said didn't need to be seen
- 2  Could not afford it/no insurance
- 3  Refused care because of lack of money or insurance
- 4  Provider did not accept Medicaid/insurance
- 5  Difficulty in getting appointment
- 6  Afraid/Embarrassed/Ashamed to go
- 7  Didn't think they could help
- 8  No provider available
- 9  Didn't know where to go
- 10  No way to get there
- 11  Hours not convenient
- 12  Speaks a different language
- 13  Health of another family member
- 88  Other reason – Specify *z* (RECORD VERBATIM)

} GO to F21

**F20. Why did (Name/you) not try to see a medical person?**

Probe: "Any other reason?"

Mark (X) all that apply.

- 1  Could not afford it
- 2  No insurance
- 3  Doctor had treated it previously
- 4  Not serious enough
- 5  Difficulty in getting appointment
- 6  Didn't think a doctor could help
- 7  Afraid/embarrassed/ashamed
- 8  Didn't want to get care
- 9  No provider available
- 10  Didn't know where to go
- 11  No way to get there
- 12  Hours not convenient
- 13  Speak a different language
- 14  Health of another family member
- 88  Other reason – Specify *z* (RECORD VERBATIM)

**F21. Was (Name's/your) health affected in any way because (Name/you) did not receive medical care?**

- 1  Yes
- 2  No – GO to F23

**F22. How was (Name's/your) health affected? (RECORD VERBATIM)**

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**F23. Did (Name/you) have any personal, household, or work problems because (Name/you) did not receive medical care for this problem?**

- 1  Yes
- 2  No – GO to next symptom in F1a-x; if no more symptoms, GO to G1

**F24. What were they? (RECORD VERBATIM)**

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*GO to next symptom in F1a-x; if no more symptoms, GO to G1*

Notes

**Section G – HEALTH BELIEFS**

**CHECK  
ITEM G**

Refer to *PROXY STATUS* and *age* on cover page to determine type of respondent. If proxy is for an adult, GO to H1. If proxy is for a child, GO to G1. If self-respondent, GO to G2.

**G1. Do you make decisions about health care for (Name)?**

- 1  Yes
- 2  No – GO to H1

**Next, I will read a few statements. After each, please tell me if you disagree strongly, disagree somewhat, agree somewhat, or agree strongly.**

**G2. "If you wait long enough, you can get over most any illness without getting medical care." (Do you disagree strongly, disagree somewhat, agree somewhat, or agree strongly?)**

- 1  Disagree strongly
- 2  Disagree somewhat
- 3  Agree somewhat
- 4  Agree strongly
- 5  UNCERTAIN/NEITHER AGREE NOR DISAGREE

**G3. "Some home remedies are still better than prescribed drugs for curing illness." (Do you disagree strongly, disagree somewhat, agree somewhat, or agree strongly?)**

- 1  Disagree strongly
- 2  Disagree somewhat
- 3  Agree somewhat
- 4  Agree strongly
- 5  UNCERTAIN/NEITHER AGREE NOR DISAGREE

**G4. "Doctors never recommend surgery (an operation) unless there is no other way to solve the problem." (Do you disagree strongly, disagree somewhat, agree somewhat, or agree strongly?)**

- 1  Disagree strongly
- 2  Disagree somewhat
- 3  Agree somewhat
- 4  Agree strongly
- 5  UNCERTAIN/NEITHER AGREE NOR DISAGREE

**G5. As you know, there has been much talk about the cost of health care in this country. Some ideas for reducing costs would affect the services people get.**

**If it meant that you would pay significantly less for health care, how much would you mind if (Name/you) couldn't see a specialist unless (he/she/you) (was/were) referred by (his/her/your) regular doctor — would you mind a lot, a little, or not at all?**

- 1  A lot
- 2  A little
- 3  Not at all

**G6. If it meant that you would pay significantly less for health care, how much would you mind if (Name/you) had to choose (his/her/your) doctor from a list provided by the insurance company — would you mind a lot, a little, or not at all?**

- 1  A lot
- 2  A little
- 3  Not at all

**G7. If it meant that you would pay significantly less for health care, how much would you mind if (Name/you) sometimes saw a nurse instead of a doctor — would you mind a lot, a little, or not at all?**

- 1  A lot
- 2  A little
- 3  Not at all

**G8. If it meant that you would pay significantly less for health care, how much would you mind if (Name/you) had to wait more than a day or two to see a doctor when (Name/you) (was/were) sick — would you mind a lot, a little, or not at all?**

- 1  A lot
- 2  A little
- 3  Not at all

Notes

**Section H - ASTHMA**

**Next, I will be asking you questions about the condition of asthma.**

**H1a. (Does/Do) (Name/you) have asthma?**

- 1  Yes
- 2  No - GO to I1

**b. About how old were you when your asthma was first diagnosed by a medical doctor?**

\_\_\_\_\_ Years old

**H2. In the past six months, (has/have) (Name/you) been hospitalized for asthma?**

- 1  Yes
- 2  No - GO to H4

**H3. How many times?**

\_\_\_\_\_ Times

**H4. In the past six months, how many times (has/have) (Name/you) had to go to a doctor's office or emergency room for *unscheduled* appointments and *urgent* treatment of asthma?**

\_\_\_\_\_ Times

**H5. (Does/Do) (Name/you) take prednisone, Medrol, or another "steroid" by mouth to control asthma?**

- 1  Yes
- 2  No - GO to H8

**H6. In the past six months, (has/have) (Name/you) had to increase and suddenly decrease (Name's/your) dose of steroids in a short time period?**

- 1  Yes
- 2  No - GO to H8

**H7. How many times has this happened in the past six months?**

\_\_\_\_\_ Times

**H8. (Is/Are) (Name/you) currently taking any other drugs for asthma?**

- 1  Yes
- 2  No - GO to H10

**H9. What drug (is/are) (Name/you) taking?**

*Probe: Any other drug?*

*Mark (X) all that apply.*

- 1  Albuterol Inhalants such as Proventil or Ventolin
- 2  Steroid Inhalants such as Azmacort
- 3  Theophylline pills such as Theo-Dur or Primatene
- 4  Other - *Specify*

**(a)** \_\_\_\_\_

**(b)** \_\_\_\_\_

**(c)** \_\_\_\_\_

**H10. Over the past four weeks, how frequently (has/have) (Name/you) had the following symptoms? What about —**

**a. coughing —**

- 1  never,
- 2  occasionally,
- 3  once or twice a day,
- 4  many times a day, or
- 5  all the time?

**b. chest tightness —**

- 1  never,
- 2  occasionally,
- 3  once or twice a day,
- 4  many times a day, or
- 5  all the time?

**c. wheezing —**

- 1  never,
- 2  occasionally,
- 3  once or twice a day,
- 4  many times a day, or
- 5  all the time?

**d. shortness of breath —**

- 1  never,
- 2  occasionally,
- 3  once or twice a day,
- 4  many times a day, or
- 5  all the time?

**Section H - ASTHMA**

**H11.** The next questions are about activities (*Name/you*) might do in a typical day. We are interested in how much (*Name's/your*) asthma limits these activities — whether a lot, a little, or not at all.

On a typical day, does (*Name's/your*) asthma limit (*him/her/you*) in —

**a.** *vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all — *GO to I1*
- 4  Not applicable

**b.** *moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all — *GO to I1*
- 4  Not applicable

**c.** *lifting or carrying groceries?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**d.** *climbing several flights of stairs?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all — *GO to H11f*
- 4  Not applicable

**e.** *climbing one flight of stairs?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**f.** *bending, kneeling, or stooping?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**g.** *walking more than a mile?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all — *GO to I1*
- 4  Not applicable

**h.** *walking several blocks?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all — *GO to I1*
- 4  Not applicable

**i.** *walking one block?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all — *GO to I1*
- 4  Not applicable

**j.** *bathing and dressing?*

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**H12.** Besides asthma, is there any other condition that might cause (this limitation/these limitations)?

- 1  Yes
- 2  No — *GO to I1*

**H13.** What other condition might cause (this limitation/these limitations)? Write in condition name. Probe with "Anything else?" until respondent indicates no other conditions.

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**Section I – ISCHEMIC HEART DISEASE**

**Next, I will be asking you questions about the condition of Ischemic Heart Disease.**

**I1a. (Has/Have) (Name/s/you) ever had angina pectoris?**

- 1  Yes  
2  No – Go to I2

*Read if necessary: Angina pectoris is a severe constricting pain that usually starts in the chest and radiates to the left shoulder and down the right arm.*

**b. About how old (was/were) (Names/you) when (his/her/your) angina pectoris was first diagnosed by a medical doctor?**

\_\_\_\_\_ Years old

**I2. (Has/Have) (Name/you) ever had a myocardial infarction or heart attack?**

- 1  Yes – GO to I3  
2  No

**CHECK ITEM I1**

Refer to I1a.

- 1  I1a is "Yes", GO to I11  
2  I1a is "No", GO to CLOSING

**I3. In what month and year did (Name/you) have heart attacks? (RECORD DATES OF UP TO THREE MOST RECENT HEART ATTACKS.)**

<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year

**I4. (Has/Have) (Name/you) ever been in the hospital overnight or longer any other times because of heart trouble or chest pain?**

- 1  Yes  
2  No

**I5. (Has/Have) (Name/you) ever had heart surgery or coronary bypass surgery?**

- 1  Yes  
2  No – GO to I7

**I6. In what month and year did (Name/you) have heart or coronary bypass surgery? (RECORD DATES OF UP TO THREE MOST RECENT SURGERIES.)**

<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year

**I7. (Has/Have) (Name/you) ever had coronary or balloon angioplasty?**

- 1  Yes  
2  No – GO to I9

**I8. In what month and year did (Name/you) have coronary or balloon angioplasty? (RECORD DATES OF UP TO THREE MOST RECENT ANGIOPLASTIES.)**

<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year

**I9. (Has/Have) (Name/you) ever had coronary catheterization, also known as a cardiac cath test?**

- 1  Yes  
2  No – GO to I11

**I10. In what month and year did (Name/you) have coronary catheterization? (RECORD DATES OF UP TO THREE MOST RECENT CATHETERIZATIONS.)**

<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year
<input type="text"/> <input type="text"/>	Month	<input type="text"/> <input type="text"/>	Year

**I11. (Does/Do) (Name/you) currently ever have pain or discomfort in the chest?**

- 1  Yes  
2  No

**I12. (Does/Do) (Name/you) ever have pressure or heaviness in the chest?**

- 1  Yes  
2  No

**CHECK ITEM I11a**

Refer to I11 and I12. If I11 and I12 are "No," GO to I18, else continue with I13.

**Section I – ISCHEMIC HEART DISEASE – Continued**

<b>I13. (Does/Do) ( Name/you) get this pain (or heaviness) when (Name/you) walk(s) up a hill in a hurry?</b>		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
<b>I14. What (does/do) (Name/you) do if (Name/you) get this pain while walking — (does/do) (Name/you) —</b>		1 <input type="checkbox"/> Stop or slow down, 2 <input type="checkbox"/> Take a nitroglycerin, 3 <input type="checkbox"/> Continue at the same pace, or 4 <input type="checkbox"/> Something else? 5 <input type="checkbox"/> NEVER GET THE PAIN WHILE WALKING – GO to I17
<b>I15. If (Name/you) stand(s) still, does the pain continue or go away?</b>		1 <input type="checkbox"/> Continues – GO to I17 2 <input type="checkbox"/> Goes away
<b>I16. How soon does the pain go away —</b>		1 <input type="checkbox"/> In 10 minutes or less, 2 <input type="checkbox"/> Or more than 10 minutes?
<b>I17. Where does the pain or discomfort occur on (Name's/your) body?</b>  Probe: <b>Anywhere else?</b>  Mark (X) all that apply.		1 <input type="checkbox"/> Middle of chest 2 <input type="checkbox"/> Lower part of chest 3 <input type="checkbox"/> Left part of chest 4 <input type="checkbox"/> Left arm 88 <input type="checkbox"/> Other – Specify <u>      </u> _____
<b>I18. (Has/Have) (Name/you) ever had severe chest pain across the front of the chest lasting half an hour or more?</b>		1 <input type="checkbox"/> Yes – GO to I19 2 <input type="checkbox"/> No – GO to CHECK ITEM I18; GO to I19
<b>CHECK ITEM I18</b>	Refer to I1a and I2. If the response to I1a and/or I2 is "Yes", ask (" You indicated that (you/Name) (have/has) had (angina pectoris) and/or (heart attack); however, you have not had severe chest pains across the front of the chest lasting half hour or more. Is this correct?")	1 <input type="checkbox"/> Yes – GO to CHECK ITEM I11b 2 <input type="checkbox"/> No – Reask I18
<b>I19. Did (Name/you) see a doctor because of this pain?</b>		1 <input type="checkbox"/> Yes – GO to CHECK ITEM I11b 2 <input type="checkbox"/> No – GO to CHECK ITEM I19; GO to I20
<b>CHECK ITEM I19</b>	Refer to I1a and I2. If the response to I1a and/or I2 is "Yes", ask ("You indicated that (you/Name) (have/has) not seen a doctor for this pain; however, earlier you indicated that (you/Name) (have/has) had angina pectoris, a heart attack, or myocardial infarction. Is this correct?")	1 <input type="checkbox"/> Yes – GO to I20 2 <input type="checkbox"/> No – Reask I19
<b>I20. Why not?</b>		1 <input type="checkbox"/> Could not afford it 2 <input type="checkbox"/> No insurance 3 <input type="checkbox"/> Doctor had treated it previously 4 <input type="checkbox"/> Not serious enough 5 <input type="checkbox"/> Difficulty in getting appointment 6 <input type="checkbox"/> Didn't think a doctor could help 7 <input type="checkbox"/> Afraid/embarrassed/ashamed 8 <input type="checkbox"/> Didn't want to get care 9 <input type="checkbox"/> No provider available 10 <input type="checkbox"/> Didn't know where to go 11 <input type="checkbox"/> No way to get there 12 <input type="checkbox"/> Hours not convenient 13 <input type="checkbox"/> Speak a different language 14 <input type="checkbox"/> Health of another family member 88 <input type="checkbox"/> Other reason – Specify <u>      </u> _____
<b>CHECK ITEM I11b</b>	Refer to I11 and I12.	1 <input type="checkbox"/> I11 or I12 is "Yes" – GO to I21 2 <input type="checkbox"/> I11 and I12 is "No" – GO to CLOSING
<b>Notes</b>		

**Section I – ISCHEMIC HEART DISEASE – Continued**

**I21. The next questions are about activities (Name/you) might do in a typical day. We are interested in how much (Name's/your) chest pain or discomfort limits these activities — whether a lot, a little, or not at all.**

**On a typical day, does (Name's/your) chest pain or discomfort limit (him/her/you) in —**

**a. vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all – GO to CLOSING
- 4  Not applicable

**b. moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all – GO to CLOSING
- 4  Not applicable

**c. lifting or carrying groceries?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**d. climbing several flights of stairs?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all – GO to I21f
- 4  Not applicable

**e. climbing one flight of stairs?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**f. bending, kneeling, or stooping?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**g. walking more than a mile?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all – GO to CLOSING
- 4  Not applicable

**h. walking several blocks?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all – GO to CLOSING
- 4  Not applicable

**i. walking one block?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all – GO to CLOSING
- 4  Not applicable

**j. bathing and dressing?**

- 1  Yes, limited a lot
- 2  Yes, limited a little
- 3  No, not limited at all
- 4  Not applicable

**I22. Besides angina pectoris, is there any other condition that might cause (this limitation/these limitations)?**

- 1  Yes
- 2  No – GO to CLOSING

Notes

**Section I - ISCHEMIC HEART DISEASE - Continued**

**123. What other condition might cause (this limitation/these limitations)?**

*Write in condition name. Probe with "Anything else?" until respondent indicates no other conditions.*

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**CLOSING**

**1. How long (has/have) (Name/you) lived in this community?**

- 1  Less than one year
- 2  One year to less than two years
- 3  Two years to less than three years
- 4  Three years to less than five years
- 5  Five years to less than ten years
- 6  Ten years or longer

**Thank you for assisting us in this important survey. Your time and effort are appreciated.**

Notes

**Section F – SYMPTOMS/RESPONSE**

**VERSION 1**

Next, I am going to ask you whether (Name/you) (has/have) had some particular health problems in the last 3 months.

<b>F1. In the past 3 months, (have/has) (Name/you) had —</b>	
<b>v. difficulty hearing conversations or telephone calls?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>a. sadness, hopelessness, frequent crying, or felt depressed?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>b. shortness of breath when lying down, waking up short of breath, or shortness of breath with light work or exercise?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>c. loss of consciousness or fainting?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>d. blurry vision or difficulty seeing?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>e. headaches that are either new or more frequent or severe than ones (Name/you) (has/have) had before?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>f. cough with yellow sputum and fever?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>g. bright red blood on the toilet paper after a bowel movement?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>h. back pain or neck pain that made it very painful to walk a block or go up a flight of stairs?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>i. anxiety, nervousness, or fear that has kept (Name/you) from doing (his/her/your) usual amount of work or social activities?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>j. pain in the hip, knee, or leg that makes it difficult to walk a block or go up a flight of stairs?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>k. a sprained ankle that is too painful to bear weight?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>l. headaches that come on two or three times per week, but have not changed in frequency or severity?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>m. fatigue, extreme tiredness, or generalized weakness?</b> <i>Ask F2n if response is "Yes".</i>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>n. sore throat, dry cough, or head cold with no fever or a low fever?</b> <i>Ask F2o if response is "Yes".</i>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>o. diarrhea or loose bowel movements without blood for only one or two days?</b> <i>Ask F2p if response is "Yes".</i>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>p. nausea or vomiting for one day or less?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>CHECK ITEM F</b>	<i>Refer to sex on cover page. If respondent is male, GO to F1t.</i>
<b>q. a lump or mass in the breast?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>r. accidental urination once a week or more?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>s. pain when urinating?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>CHECK ITEM F1</b>	<i>Refer to age on cover page. If respondent is less than 25, GO to F1x. If respondent is between the age of 25 and 40, GO to F2-INSTRUCTIONS. If respondent is over 40 and female, GO to F1w.</i>
<b>t. pain, mass, or swelling in the groin or crotch?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>u. a great deal of difficulty starting urination or passing urine?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>w. chest pain that lasted more than a minute?</b> <i>Mark (X) "Yes", or "No", Then GO to F2-INSTRUCTIONS</i>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
<b>x. acne that leaves scars and does not improve with over-the-counter medication?</b>	1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No

**Section F - SYMPTOMS/RESPONSE**

**VERSION 2**

Next, I am going to ask you whether (Name/you) (has/have) had some particular health problems in the last 3 months.

**F1. In the past 3 months, (have/has) (Name/you) had —**

- |                                                                                                                                       |                                |                               |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------|
| <b>v. difficulty hearing conversations or telephone calls?</b>                                                                        | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>k. a sprained ankle that is too painful to bear weight?</b>                                                                        | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>l. headaches that come on two or three times per week, but have not changed in frequency or severity?</b>                          | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>m. fatigue, extreme tiredness, or generalized weakness?</b><br><i>Ask F2n if response is "Yes".</i>                                | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>n. sore throat, dry cough, or head cold with no fever or a low fever?</b><br><i>Ask F2o if response is "Yes".</i>                  | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>o. diarrhea or loose bowel movements without blood for only one or two days?</b><br><i>Ask F2p if response is "Yes".</i>           | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>p. nausea or vomiting for one day or less?</b>                                                                                     | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>h. back pain or neck pain that made it very painful to walk a block or go up a flight of stairs?</b>                               | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>i. anxiety, nervousness, or fear that has kept (Name/you) from doing (his/her/your) usual amount of work or social activities?</b> | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>j. pain in the hip, knee, or leg that makes it difficult to walk a block or go up a flight of stairs?</b>                          | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>g. bright red blood on the toilet paper after a bowel movement?</b>                                                                | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>d. blurry vision or difficulty seeing?</b>                                                                                         | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>e. headaches that are either new or more frequent or severe than ones (Name/you) (has/have) had before?</b>                        | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>f. cough with yellow sputum and fever?</b>                                                                                         | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>a. sadness, hopelessness, frequent crying, or felt depressed?</b>                                                                  | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>b. shortness of breath when lying down, waking up short of breath, or shortness of breath with light work or exercise?</b>         | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>c. loss of consciousness or fainting?</b>                                                                                          | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |

**CHECK ITEM F**

*Refer to sex on cover page. If respondent is male, GO to F1t.*

- |                                                     |                                |                               |
|-----------------------------------------------------|--------------------------------|-------------------------------|
| <b>q. a lump or mass in the breast?</b>             | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>r. accidental urination once a week or more?</b> | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>s. pain when urinating?</b>                      | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |

**CHECK ITEM F1**

*Refer to age on cover page. If respondent is less than 25, GO to F1x. If respondent is between the age of 25 and 40, GO to F2-INSTRUCTIONS. If respondent is over 40 and female, GO to F1w.*

- |                                                                                                                    |                                |                               |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------|
| <b>t. pain, mass, or swelling in the groin or crotch?</b>                                                          | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>u. a great deal of difficulty starting urination or passing urine?</b>                                          | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>w. chest pain that lasted more than a minute?</b><br><i>Mark (X) "Yes", or "No", Then GO to F2-INSTRUCTIONS</i> | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| <b>x. acne that leaves scars and does not improve with over-the-counter medication?</b>                            | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |

**CARD O**

**ORIGIN**

- 1. Puerto Rican
- 2. Cuban
- 3. Mexican/Mexicano
- 4. Mexican American
- 5. Chicano
- 6. Other Latin American
- 7. Other Spanish

**CARD R**

- 1. White
- 2. Black
- 3. Indian (American)
- 4. Eskimo
- 5. Aleut
- Asian or Pacific Islander (API)
- 6. Chinese
- 7. Filipino
- 8. Hawaiian
- 9. Korean
- 10. Vietnamese
- 11. Japanese
- 12. Asian Indian
- 13. Samoan
- 14. Guamanian
- 15. Other API (*Specify*)

O  
R

(Cut along broken lines)

**CARD I**

**INCOME**

- U ... \$20,000 – \$24,999
- V ... \$25,000 – \$29,999
- W ... \$30,000 – \$34,999
- X ... \$35,000 – \$39,999
- Y ... \$40,000 – \$44,999
- Z ... \$45,000 – \$49,999
- ZZ ... \$50,000 and over

**CARD J**

**INCOME**

- A ... Less than \$1,000 (including loss)
- B ... \$1,000 – \$1,999
- C ... \$2,000 – \$2,999
- D ... \$3,000 – \$3,999
- E ... \$4,000 – \$4,999
- F ... \$5,000 – \$5,999
- G ... \$6,000 – \$6,999
- H ... \$7,000 – \$7,999
- I ... \$8,000 – \$8,999
- J ... \$9,000 – \$9,999
- K ... \$10,000 – \$10,999
- L ... \$11,000 – \$11,999
- M ... \$12,000 – \$12,999
- N ... \$13,000 – \$13,999
- O ... \$14,000 – \$14,999
- P ... \$15,000 – \$15,999
- Q ... \$16,000 – \$16,999
- R ... \$17,000 – \$17,999
- S ... \$18,000 – \$18,999
- T ... \$19,000 – \$19,999

I  
J

(Cut along broken lines)

**CARD DA1**

- 1. A Cane**
- 2. Crutches**
- 3. A walker**
- 4. Medically prescribed shoes**
- 5. A manual wheelchair**
- 6. An electric wheelchair**
- 7. A scooter**

**CARD DC1**

- 1. Bathing or showering**
- 2. Dressing**
- 3. Eating**
- 4. Getting in and out of bed or chairs**
- 5. Using the toilet, including getting to the toilet**
- 6. Getting around inside your home**

Card DA1  
Card DC1

(Cut along broken lines)

**CARD DC2**

- 1. Preparing their own meals**
- 2. Shopping for personal items, such as toilet items or medicines**
- 3. Managing money, such as keeping track of expenses or paying bills**
- 4. Using the telephone**
- 5. Doing HEAVY work around the house like scrubbing floors, washing windows, doing heavy yard work**
- 6. Doing LIGHT work around the house like doing dishes, straightening up, light cleaning, or taking out the trash**

**CARD DG1**

- 0. Parent**
- 1. Other relative who lives here**
- 2. Other relative who does not live here**
- 3. Non-relative who lives here**
- 4. Friend/Neighbor**
- 5. Unpaid volunteer from an organization or business**
- 6. Paid employee of an organization or business**
- 7. Paid employee of yours**
- 8. Other**
- 9. DK**

Card DC2  
Card DG1

(Cut along broken lines)

**CARD DG2**

- 00. Parent**
- 01. Other family member in HH**
- 02. Other family member not in HH**
- 03. Private insurance**
- 04. Rehabilitation program**
- 05. Medicaid**
- 06. Public school system**
- 07. Other public source**
- 08. Other private source**
- 09. Other**
- 99. DK or Refused**

**CARD DH1**

- 1. Under 4 months**
- 2. 4–8 months**
- 3. 9–15 months**
- 4. 16–29 months**
- 5. 30–59 months**

Card DG2  
Card DH1

(Cut along broken lines)

**CARD DJ1**

- 1. Not old enough yet**
- 2. Illness**
- 3. Receiving home teaching by parents or others**
- 4. Permanently expelled/suspended from school**
- 5. Quit school to get a job**
- 6. Quit school for other reason**
- 7. Graduated**
- 8. Other**
- 9. Don't know**

**CARD DJ2**

- A. Understanding instructional materials**
- B. Paying attention in class**
- C. Following rules or controlling his/her behavior**
- D. Communicating with teachers and other students**

Card DJ1  
Card DJ2

(Cut along broken lines)

**CARD FA1**

- 1. Two or more usual doctors/places
- 2. Doesn't need a doctor
- 3. Doesn't like/trust/believe in doctors
- 4. Doesn't know where to go
- 5. Previous doctor is not available/moved
- 6. No insurance/Can't afford it
- 7. Speak a different language
- 8. No care available/Care too far away, not convenient
- 98. Other (Specify)

**CARD FA2**

- 1. Changed residence/moved
- 2. Changed jobs
- 3. Employer changed insurance coverage
- 4. Former usual source left area
- 5. Owed money to former usual source
- 6. Dissatisfied with former source/liked new source better
- 7. Medical care needs changed
- 8. Former usual source stopped taking insurance/coverage
- 98. Other (Specify)

Card FA1  
Card FA2

---  
Cut along broken lines  
---

**MEDICARE**

<b>Health Insurance</b>	
<small>SOCIAL SECURITY ACT</small>	
<small>NAME OF BENEFICIARY</small> <b>JOHN Q. PUBLIC</b>	
<small>CLAIM NUMBER</small> <b>000-00-0000-A</b>	<small>SEX</small> <b>MALE</b>
<small>IS ENTITLED TO</small> <b>HOSPITAL INSURANCE</b>	<small>EFFECTIVE DATE</small> <b>7-1-66</b>
<b>MEDICAL INSURANCE</b>	<b>7-1-66</b>
<small>SIGN HERE</small> <i>John Q. Public</i>	

**STATE NAMES FOR MEDICAID**

**MEDI — CAL**

California

**TITLE 19**

Connecticut

**MEDI — KAN**

Kansas

**STATE ADMINISTERED MEDICAL INSURANCE (SAMI)**

Nevada

**BLUE CARD OR GREEN CARD**

Pennsylvania

**HEALTH CARE COST CONTAINMENT SYSTEM (HCCCS)**

Arizona

**MEDICAL ASSISTANCE**

All other States

Medicare  
State names  
for Medicaid

**CARD FC1**

- 1. Zero
- 2. \$ 1 - \$ 9
- 3. \$ 10 - \$ 19
- 4. \$ 20 - \$ 49
- 5. \$ 50 - \$ 99
- 6. \$100 - \$199
- 7. \$200 - \$499
- 8. \$500 or more

**CARD FC2**

- 1. Job layoff/loss/unemployment
- 2. Wasn't offered by employer
- 3. Not eligible because part time worker
- 4. Family coverage not offered by employer
- 5. Benefits from former employer ran out
- 6. Can't obtain because of poor health, illness, or age
- 7. Too expensive/Can't afford
- 8. Dissatisfied with previous insurance
- 9. Don't believe in insurance
- 10. Have usually been healthy, haven't needed insurance
- 11. Covered by some other plan
- 12. Too old for coverage under family plans
- 13. Free/inexpensive source of care readily available
- 98. Other reason *(Specify)*

Card FC1  
Card FC2

(Cut along broken lines)

**CARD FC3**

- 1. Lost job or changed employers
- 2. Spouse/parent lost job or changed employers
- 3. Death of spouse or parent
- 4. Became divorced or separated
- 5. Became ineligible because of age
- 6. Employer stopped offering coverage
- 7. Cut back to part time
- 8. Benefits from employer/former employer ran out
- 98. Other *(Specify)*

**CARD FC4**

- 1. Zero
- 2. Less than \$500
- 3. \$ 500 - \$1,999
- 4. \$2,000 - \$2,999
- 5. \$3,000 - \$4,999
- 6. \$5,000 or more

Card FC3  
Card FC4

(Cut along broken lines)

**CARD FD1**

1. 1 - 9 employees
2. 10 - 24 employees
3. 25 - 49 employees
4. 50 - 99 employees
5. 100 - 499 employees
6. 500 - 999 employees
7. 1000 or more employees

**CARD FD2**

1. \$ 25 - \$ 99
2. \$ 100 - \$ 499
3. \$ 500 - \$ 999
4. \$1,000 - \$4,999
5. \$5,000 or more

Card FD1  
Card FD2

(Cut along Broken Lines)

**CARD FD3**

1. Less than \$ 2,000
2. \$ 2,000 - \$ 4,999
3. \$ 5,000 - \$ 9,999
4. \$10,000 - \$19,999
5. \$20,000 - \$49,999
6. \$50,000 - \$99,999
7. \$100,000 or more

**CARD FD4**

1. Less than \$25,000
2. \$ 25,000 - \$ 49,999
3. \$ 50,000 - \$ 99,999
4. \$100,000 - \$199,999
5. \$200,000 - \$299,999
6. \$300,000 - \$499,999
7. \$500,000 or more

Card FD3  
Card FD4

(Cut along Broken Lines)

**CARD FD5**

- 1. Less than \$500**
- 2. \$ 500 – \$ 999**
- 3. \$1,000 – \$1,999**
- 4. \$2,000 or more**

**CARD YC1**

- 1. Work mainly indoors**
- 2. Work mainly outdoors**
- 3. Travel to different buildings or sites**
- 4. In a motor vehicle**
- 5. Other (Specify)**

Card FD5  
Card YC1

(Cut along broken lines)

**CARD YC2**

- 1. Not allowed in ANY indoor common areas**
- 2. Allowed in SOME indoor common areas including designated smoking areas**
- 3. Allowed in ALL indoor common areas**

**CARD YC3**

- 1. Not allowed in ANY work areas**
- 2. Allowed in SOME work areas**
- 3. Allowed in ALL work areas**

Card YC2  
Card YC3

(Cut along broken lines)

**CARD YC4**

- 1. Gymnasium/Exercise room**
- 2. Weight lifting equipment**
- 3. Exercise equipment**
- 4. Walking/Jogging path**
- 5. Parcours/Fitness trails**
- 6. Bike path**
- 7. Bike racks**
- 8. Swimming pool**
- 9. Showers**
- 10. Lockers**
- 11. Other (Specify)**
- 00. No facilities**

**CARD YC5**

- 1. Walking group**
- 2. Jogging/Running group**
- 3. Biking/Cycling group**
- 4. Aerobics class**
- 5. Swimming class**
- 6. Non-aerobic exercise class**
- 7. Weight lifting class**
- 8. Fully paid membership in health/fitness club**
- 9. Partially paid membership in health/fitness club**
- 10. Physical activity or exercise competitions**
- 11. Other (Specify)**
- 00. No Programs**

Card YC4  
Card YC5

(Cut along broken lines)

**CARD YC6**

- 1. Weight control**
- 2. Nutrition information**
- 3. Prenatal education**
- 4. Stress reduction and management**
- 5. Alcohol and other drugs**
- 6. Sexually transmitted diseases (including HIV or AIDS)**
- 7. Job hazards and injury prevention**
- 8. Back care and prevention of back injury**
- 9. Preventing off-the-job accidents**
- 10. Other (Specify)**
- 00. None**

**CARD YG1**

- 1. The firearm is kept in a LOCKED PLACE, such as a drawer, cabinet, or closet**
- 2. The firearm is kept in an UNLOCKED place**

Card YC6  
Card YG1

(Cut along broken lines)

**CARD YG2**

1. Taken apart
2. With a trigger lock or other locking mechanism
3. Assembled without a locking mechanism
4. Other (*Specify*)

**CARD YG3**

1. ALL the firearms are kept in LOCKED PLACES, such as drawers, cabinets, or closets
2. One or more firearms are kept in an UNLOCKED PLACE
9. DK

Card YG2  
Card YG3

(Cut along broken lines)

**CARD A1**

1. Very likely
2. Somewhat likely
3. Somewhat unlikely
4. Very unlikely
5. Definitely not possible

**CARD A2**

1. A church or other religious organization
2. A family planning clinic or STD clinic
3. A hospital, HMO clinic or other health facility
4. A school
5. A social or civic club
6. Your workplace
7. Some other place (*Specify*)
8. Attended no programs

Card A1  
Card A2

(Cut along broken lines)

**CARD A3**

1. **Just to find out/I am worried that I am infected**
2. **Because a doctor asked you to**
3. **Because the Health Dept. asked you to**
4. **Because a sex partner asked you to**
5. **For hospitalization or a surgical procedure**
6. **To apply for health or life insurance**
7. **To comply with guidelines for health workers**
8. **To apply for a new job**
9. **For military induction, separation or during military service**
10. **For immigration**
11. **For some other reason** *(Please specify the other reason or reasons)*

**CARD A4**

1. **How AIDS is transmitted**
2. **How to prevent transmission**
3. **The correct use of condoms**
4. **Needle cleaning/using clean needles**
5. **Dangers of needle sharing**
6. **Abstinence from sex**
7. **Contraception**
8. **Safe sex practices**
9. **Other** *(Please specify what other topics)*

Card A3  
Card A4

(Cut along broken lines)

**CARD A5**

1. **Because you want to find out if you are infected**
2. **It will be part of hospitalization or surgery you expect to have**
3. **Because you expect to apply for life or health insurance**
4. **Because you expect to apply for a job**
5. **Because you expect to join the military**
6. **Because of guidelines for health care workers**
7. **Because it will be a required part of some other activity that includes automatic AIDS testing**
8. **Because it is required in your non-health care employment**
9. **Because you plan to have/begin a sexual relationship**
10. **Some other reason** *(Please specify what other reason or reasons)*

**CARD A6**

- a. **You have hemophilia and have received clotting factor concentrations.**
- b. **You are a man who has had sex with another man at some time since 1980, even one time.**
- c. **You have taken street drugs by needle at any time since 1980.**
- d. **You have traded sex for money or drugs at any time since 1980.**
- e. **Since 1980, you are or have been the sex partner of any person who would answer "Yes" to any of the items above on this card.**

Card A5  
Card A6

(Cut along broken lines)

**CARD A7**

- 1. Breathing the air around a person who is sick with TB**
- 2. Through food and water**
- 3. By sexual intercourse**
- 4. It is inherited from parents**
- 5. From mosquito or other insect bites**
- 6. Other (*Specify*)**

**CARD A8**

- 0. Diaphragm**
- 1. Condom (rubber)**
- 2. IUD (loop, coil)**
- 3. Rhythm (safe period by calendar)**
- 4. Foam**
- 5. Pill**
- 6. Withdrawal (pulling out)**

Card A7  
Card A8

# Vital and Health Statistics series descriptions

- SERIES 1. **Programs and Collection Procedures**—These reports describe the data collection programs of the National Center for Health Statistics. They include descriptions of the methods used to collect and process the data, definitions, and other material necessary for understanding the data.
- SERIES 2. **Data Evaluation and Methods Research**—These reports are studies of new statistical methods and include analytical techniques, objective evaluations of reliability of collected data, and contributions to statistical theory. These studies also include experimental tests of new survey methods and comparisons of U.S. methodology with those of other countries.
- SERIES 3. **Analytical and Epidemiological Studies**—These reports present analytical or interpretive studies based on vital and health statistics. These reports carry the analyses further than the expository types of reports in the other series.
- SERIES 4. **Documents and Committee Reports**—These are final reports of major committees concerned with vital and health statistics and documents such as recommended model vital registration laws and revised birth and death certificates.
- SERIES 5. **International Vital and Health Statistics Reports**—These reports are analytical or descriptive reports that compare U.S. vital and health statistics with those of other countries or present other international data of relevance to the health statistics system of the United States.
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- SERIES 24. **Compilations of Data on Natality, Mortality, Marriage, Divorce, and Induced Terminations of Pregnancy**—These include advance reports of births, deaths, marriages, and divorces based on final data from the National Vital Statistics System that were published as supplements to the *Monthly Vital Statistics Report (MVSR)*. These reports provide highlights and summaries of detailed data subsequently published in *Vital Statistics of the United States*. Other supplements to the MVSR published here provide selected findings based on final data from the National Vital Statistics System and may be followed by detailed reports in Series 20 or 21.

For answers to questions about this report or for a list of reports published in these series, contact:

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