

Table I - ILLNESSES, IMPAIRMENTS, AND INJURIES										
Line number	Col. No. of person	Question No.	Did you EVER or any time talk to a doctor about ...?	Ask for all illnesses and present effects of old injuries: (a) If doctor talked to: What did the doctor say it was? — did he give it a medical name? (b) If doctor not talked to: Record original entry and ask: (d-2) - (d-5) as required. Ask for all injuries during past 2 weeks: What part of the body was hurt? What kind of injury was it? Anything else? (Also, fill Table A for all injuries)	Ask if the entry in Col. (d-1) is: An Impairment, or a Symptom, or came from Question 11 or 13. What was the cause of ...? (If "Cause" is an injury, also fill Table A)	Ask only if: 6 years old or over and blindness, poor vision, or eye trouble of any kind. Can you see well enough to read ordinary newspaper print with glasses?	Ask for any entry in Col. (d-1) or Col. (d-2) that includes the words: Allergy* Tumor Asthma "Condition" Cyst "Disease" Growth "Trouble" Stroke* What kind of ... is it? *For an allergy or stroke ask: How does the allergy (stroke) affect you?	Ask only for: Impairments and injuries And for: Abscesses Inflammation Aches Neuralgia Bleeding Neuritis Blood Clot Pains Boils Sores Cancer Soreness Cyst Tumor Growth Ulcers Infection Weakness What part of the body is affected? Show detail for: Ear or eye - (One or both) Head - (Skull, scalp, face) Back - (Upper, middle, lower) Arm - (Shoulder, upper, elbow, lower, wrist, hand; one or both) Leg - (Hip, upper, knee, lower, ankle, foot; one or both)	LAST WEEK OR THE WEEK BEFORE did ... cause you to cut down on the things you usually do?	
									Check one?	
(a)	(b)	(c)	(d-1)	(d-2)	(d-3)	(d-4)	(d-5)	(e)	(f)	
1		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				
2		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				
3		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				
4		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				
5		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				

Table II - HOSPITALIZATION DURING PAST 12 MONTHS									
Line number	Col. No. of person	Question No.	USE YOUR CALENDAR					For what condition did you enter the hospital — do you know the medical name? (If medical name not known, enter respondent's description.) (Entry must show "Cause," "Kind," and "Part of body" in same detail as required in Table I.)	
			You said that you were in the hospital (once, twice, etc.) during the past year — When did you enter the hospital (the last time)? (Enter month, day and year; if exact date not known, obtain estimate.)			How many nights were you in the hospital? (If exact number not known accept best estimate)	Complete from entries in Columns (c) and (d); or, if not clear ask the questions.		Was this person still in the hospital last Sunday night?
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)		
1		Month _____ Day _____ Year _____	Nights _____	Nights _____	Nights _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2		Month _____ Day _____ Year _____	Nights _____	Nights _____	Nights _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3		Month _____ Day _____ Year _____	Nights _____	Nights _____	Nights _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4		Month _____ Day _____ Year _____	Nights _____	Nights _____	Nights _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Table A - ACCIDENTS AND INJURIES				
Line No. from Table I	1. When did the accident happen?		2. At the time of the accident, what part of the body was hurt? What kind of injury was it? Anything else?	
	Year	Month	Part(s) of body	Kind of injury (injuries)
<input type="checkbox"/>	(If 1961, 1962, or 1963 also enter month):			
Accident happened last week or week before (Go to Q. 3)				
3. (a) Was a car, truck, bus or other motor vehicle involved in the accident in any way?			<input type="checkbox"/> Yes	<input type="checkbox"/> No (Go to Q. 4)
(b) Was more than one motor vehicle involved?			<input type="checkbox"/> Yes (More than one)	<input type="checkbox"/> No
(c) Was it (either one) moving at the time?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. (a) Where did the accident happen — at home or some other place?				
1. <input type="checkbox"/> At home (inside house)			2. <input type="checkbox"/> At home (adjacent premises) <input type="checkbox"/> Some other place	
If "Some other place," ask:				
(b) What kind of place was it?				
3. <input type="checkbox"/> Street and highway (includes roadway)			6. <input type="checkbox"/> School (includes school premises)	
4. <input type="checkbox"/> Farm			7. <input type="checkbox"/> Place of recreation and sports, except at school	
5. <input type="checkbox"/> Industrial place (includes premises)			8. <input type="checkbox"/> Other (Specify the place where accident happened)	
5. Were you at work at your job or business when the accident happened?				
1. <input type="checkbox"/> Yes		2. <input type="checkbox"/> No		4. <input type="checkbox"/> Under 17 at time of accident
			3. <input type="checkbox"/> While in Armed Services	

**Table I - ILLNESSES, IMPAIRMENTS, AND INJURIES**

Did you have to cut down for as much as a day?	How many days during that two-week period?	During that two week period, how many days did you keep you in bed all or most of the day?	If 6-16 years old ask: How many days did you keep you from school last week or the week before?	If 17 years old or over ask: LAST WEEK or the WEEK BEFORE how many days did you keep you from work? (For females add) not counting work around the house?	Did you first notice ... (did it happen) during the past 3 months OR before that time?		To interviewer: CONTINUE if Col. (k) is checked, or the condition is on Card A or is an impairment; otherwise, STOP	About how many days during the past 12 months has ... kept you in bed all or most of the day?	If 1 or more more days in Col. (n) and Col. (e) is checked, ask: How many of these days were during last week or the week before?	Were you EVER hospitalized for this condition?	Ask after completing last condition for each person.			Line number		
					Check one	Check one					Check one	Please look at each statement on this card. Then tell me which statement fits you best, in terms of health. (Show Cards D-G, as appropriate)	If "1", "2", or "3" in Col. (q): Is this because of any of the conditions you have told me about?		If "Yes" in Col. (r): Which? (Enter X on line for each condition named)	
(f-1)	(f-2)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(aa)	(n)	(o)	(p)	(q)	(r)	(s)	
		____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None		<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.				____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		1
		____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None		<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.				____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		2
		____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None		<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.				____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		3
		____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None		<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.				____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		4
		____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None		<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.				____ Days or <input type="checkbox"/> None	____ Days or <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		5

**Table II - HOSPITALIZATION DURING PAST 12 MONTHS**

Were any operations performed on you during this stay at the hospital? If "Yes," ask: (a) What was the name of the operation? (b) Any other operations?	What is the name and address of the hospital you were in? (Enter full name of hospital, street or highway on which it is located, city and State; if city not known, enter county.)	To interviewer Carry this condition through Table I, if it does not appear there and "1" or more nights in Col. (f) or an Impairment or a Condition on Card A (x)	Line number
(i)	(j)	(x)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of hospital Street City and State		1
<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of hospital Street City and State		2
<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of hospital Street City and State		3
<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of hospital Street City and State		4

**Table A - ACCIDENTS AND INJURIES**

Line No. from Table I	1. When did the accident happen?		2. At the time of the accident, what part of the body was hurt? What kind of injury was it? Anything else?	
	Year	(If 1961, 1962, or 1963 also enter month): Month	Part(s) of body	Kind of injury (injuries)
Accident happened last week or week before (Go to Q. 3)				
3. (a) Was a car, truck, bus or other motor vehicle involved in the accident in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No (Go to Q. 4)				
(b) Was more than one motor vehicle involved? <input type="checkbox"/> Yes (More than one) <input type="checkbox"/> No				
(c) Was it (either one) moving at the time? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. (a) Where did the accident happen — at home or some other place? 1. <input type="checkbox"/> At home (inside house)      2. <input type="checkbox"/> At home (adjacent premises) <input type="checkbox"/> Some other place				
If "Some other place," ask: (b) What kind of place was it? 3. <input type="checkbox"/> Street and highway (includes roadway)      6. <input type="checkbox"/> School (includes school premises) 4. <input type="checkbox"/> Farm      7. <input type="checkbox"/> Place of recreation and sports, except at school 5. <input type="checkbox"/> Industrial place (includes premises)      8. <input type="checkbox"/> Other (Specify the place where accident happened) _____				
5. Were you at work at your job or business when the accident happened? 1. <input type="checkbox"/> Yes      2. <input type="checkbox"/> No      3. <input type="checkbox"/> While in Armed Services      4. <input type="checkbox"/> Under 17 at time of accident				

<p><b>Card A</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p style="text-align: center;"><b>Check List of Chronic Conditions</b></p> <p>Has anyone in the family had any of these conditions during the past 12 months?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ol style="list-style-type: none"> <li>1. Asthma</li> <li>2. Tuberculosis</li> <li>3. Chronic bronchitis</li> <li>4. Repeated attacks of sinus trouble</li> <li>5. Rheumatic fever</li> <li>6. Hardening of the arteries</li> <li>7. High blood pressure</li> <li>8. Heart trouble.</li> <li>9. Stroke</li> <li>10. Trouble with varicose veins</li> <li>11. Hemorrhoids or piles</li> <li>12. Hay fever</li> <li>13. Tumor, cyst or growth</li> <li>14. Chronic gallbladder or liver trouble</li> <li>15. Stomach ulcer</li> </ol> </td> <td style="width: 50%; vertical-align: top;"> <ol style="list-style-type: none"> <li>16. Any other chronic stomach trouble</li> <li>17. Kidney stones or chronic kidney trouble</li> <li>18. Mental illness</li> <li>19. Arthritis or rheumatism</li> <li>20. Diabetes</li> <li>21. Thyroid trouble or goiter</li> <li>22. Any allergy</li> <li>23. Epilepsy</li> <li>24. Chronic nervous trouble</li> <li>25. Cancer</li> <li>26. Chronic skin trouble</li> <li>27. Hernia or rupture</li> <li>28. Prostate trouble</li> </ol> </td> </tr> </table>	<ol style="list-style-type: none"> <li>1. Asthma</li> <li>2. Tuberculosis</li> <li>3. Chronic bronchitis</li> <li>4. Repeated attacks of sinus trouble</li> <li>5. Rheumatic fever</li> <li>6. Hardening of the arteries</li> <li>7. High blood pressure</li> <li>8. Heart trouble.</li> <li>9. Stroke</li> <li>10. Trouble with varicose veins</li> <li>11. Hemorrhoids or piles</li> <li>12. Hay fever</li> <li>13. Tumor, cyst or growth</li> <li>14. Chronic gallbladder or liver trouble</li> <li>15. Stomach ulcer</li> </ol>	<ol style="list-style-type: none"> <li>16. Any other chronic stomach trouble</li> <li>17. Kidney stones or chronic kidney trouble</li> <li>18. Mental illness</li> <li>19. Arthritis or rheumatism</li> <li>20. Diabetes</li> <li>21. Thyroid trouble or goiter</li> <li>22. Any allergy</li> <li>23. Epilepsy</li> <li>24. Chronic nervous trouble</li> <li>25. Cancer</li> <li>26. Chronic skin trouble</li> <li>27. Hernia or rupture</li> <li>28. Prostate trouble</li> </ol>	<p><b>Card B</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p style="text-align: center;"><b>Check List of Selected Impairments</b></p> <p>Does anyone in the family have any of these conditions?</p> <ol style="list-style-type: none"> <li>1. Deafness or serious trouble hearing with one or both ears</li> <li>2. Serious trouble seeing with one or both eyes even when wearing glasses</li> <li>3. Cleft palate</li> <li>4. Any speech defect</li> <li>5. Missing fingers, hand, or arm—toes, foot, or leg</li> <li>6. Palsy</li> <li>7. Paralysis of any kind</li> <li>8. Repeated trouble with back or spine</li> <li>9. Club foot</li> <li>10. Permanent stiffness or any deformity of the foot, leg, fingers, arm or back</li> <li>11. Any condition present since birth</li> </ol>	<p><b>Card D</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p>For:</p> <p><b>Workers and other persons except Housewives and Children</b></p> <ol style="list-style-type: none"> <li>1. Not able to work at all.</li> <li>2. Able to work but limited in amount of work or kind of work.</li> <li>3. Able to work but limited in kind or amount of other activities.</li> <li>4. Not limited in any of these ways.</li> </ol>
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<p><b>Card E</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p>For: <b>Housewife</b></p> <ol style="list-style-type: none"> <li>1. Not able to keep house at all.</li> <li>2. Able to keep house but limited in amount or kind of housework.</li> <li>3. Able to keep house but limited in kind or amount of other activities.</li> <li>4. Not limited in any of these ways.</li> </ol>	<p><b>Card F</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p>For:</p> <p><b>Children from 6 through 16 years old</b></p> <ol style="list-style-type: none"> <li>1. Not able to go to school at all.</li> <li>2. Able to go to school but limited to certain types of schools or in school attendance.</li> <li>3. Able to go to school but limited in other activities.</li> <li>4. Not limited in any of these ways.</li> </ol>	<p><b>Card G</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p>For: <b>Children under 6 years old</b></p> <ol style="list-style-type: none"> <li>1. Not able to take part at all in ordinary play with other children.</li> <li>2. Able to play with other children but limited in amount or kind of play.</li> <li>4. Not limited in any of these ways.</li> </ol>	<p><b>Card H</b></p> <p style="text-align: center;"><b>NATIONAL HEALTH SURVEY</b></p> <p>Family income during past 12 months</p> <p>Group A. Under \$500 (including loss)</p> <p>Group B. \$500 - \$999</p> <p>Group C. \$1,000 - \$1,999</p> <p>Group D. \$2,000 - \$2,999</p> <p>Group E. \$3,000 - \$3,999</p> <p>Group F. \$4,000 - \$4,999</p> <p>Group G. \$5,000 - \$6,999</p> <p>Group H. \$7,000 - \$9,999</p> <p>Group I. \$10,000 and over</p>	