

Line Number	Col. No. of person	Question No.	Did you ever AT ANY TIME talk to a doctor about . . . ?	CAUSE			KIND		PART (OF BODY)	
				For all illnesses and present effects of "old" injuries (a) If doctor talked to, ask: 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-4) as required.	If the entry in Col. (d-1) is An IMPAIRMENT, or a SYMPTOM or	came from Question 11 or 13, ask: What was the cause of . . . ? (If "Cause" is an injury, also fill Table A)	For any entry in Col. (d-1) or Col. (d-2) that includes the words: Allergy* Tumor Asthma "Condition" Cyst "Disease" Growth "Trouble" Stroke*	Ask only for: IMPAIRMENTS, "CURRENT" INJURIES and PRESENT EFFECTS OF "OLD" INJURIES	Ask only for: IMPAIRMENTS, "CURRENT" INJURIES and PRESENT EFFECTS OF "OLD" INJURIES	
(a)	(b)	(c)	(d-1)	(d-2)	(d-3)	(d-4)				
6		<input type="checkbox"/> Yes <input type="checkbox"/> No			x		x			
7		<input type="checkbox"/> Yes <input type="checkbox"/> No			x		x			
8		<input type="checkbox"/> Yes <input type="checkbox"/> No			x		x			
9		<input type="checkbox"/> Yes <input type="checkbox"/> No			x		x			
10		<input type="checkbox"/> Yes <input type="checkbox"/> No			x		x			

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 question:	How many of these — nights were in the past 12 months?	How many of these — nights were last week or the week before?	
(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				

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 (injury)
<input type="checkbox"/> Accident happened last week or week before (Go to Q. 3)	(If 1962, 1963, or 1964 also enter month):			
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 (110 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				
Interviewer: Return to Table I and complete the rest of this line.				
FOOTNOTES AND COMMENTS				

Table I - ILLNESSES, IMPAIRMENTS, AND INJURIES																
LAST WEEK OR THE WEEK BEFORE did... cause you to cut down on the things you usually do?	Did you have to cut down for as much as a day?	How many days did you have to cut down during that two-week period?	During that two-week period, how many days did... keep you in bed all or most of the day?	If 6-16 years old ask: How many days did... keep you from school LAST WEEK OR THE WEEK BEFORE?	If 17 yrs. old or over ask: LAST WEEK OR THE WEEK BEFORE how many days did... 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?		If Col. (k-1) is checked ask: Did you first notice it during the past 12 months or before that time?	To interview: CONTINUE if Col. (k-1) is checked, or the condition is on Card A or is an impairment; otherwise, STOP (aa)	ABOUT how many days during the past 12 months has... kept you in bed all or most of the day?	If 1 or more days in Col. (l) and Col. (h) is blank or checked "None" ask: How many of these days were during last week or the week before?	Ask after completing last condition for each person. 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)				
						Check one: No (Go to Col. (e)) Yes (Go to Col. (f))	Check one: No (Go to Col. (f-1)) Yes (Go to Col. (f-2))						Check one: No (Go to Col. (i)) Yes (Go to Col. (j))	Check one: No (Go to Col. (k-4)) Yes (Go to Col. (k-3))	Check one: No (Go to Col. (l)) Yes (Go to Col. (m))	Check one: No (Go to Col. (n)) Yes (Go to Col. (o))
(e)	(f)	(f-1)	(f-2)	(g)	(h)	(i)	(j)	(k-1)	(k-2)	(k-3)	(k-4)	(l)	(m)	(n)	(o)	(p)
				Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1
				Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2
				Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3
				Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	4
				Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	<input type="checkbox"/> 3-12 months <input type="checkbox"/> Before 12 months	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	5

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?	Ask Col. (j) - (n) ONLY for completed hospitalizations ("No" in Col. (g)) AND delivery or operation shown in Col. (h) or Col. (i)					TABLE II - HOSPITALIZATIONS Ask for all hospitalizations	
	(i)	(j)	(k)	(l)	(m)	(n)	(o)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (Go to Col. (j)) <input type="checkbox"/> No (Go to Col. (k))	<input type="checkbox"/> Yes (Go to Col. (l)) <input type="checkbox"/> No (Go to Col. (m))	<input type="checkbox"/> Yes (Go to Col. (n)) <input type="checkbox"/> No (Go to Col. (o))	<input type="checkbox"/> Yes (Go to Col. (p)) <input type="checkbox"/> No (Go to Col. (q))	<input type="checkbox"/> Yes (Go to Col. (r)) <input type="checkbox"/> No (Go to Col. (s))	<input type="checkbox"/> Yes insurance <input type="checkbox"/> Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnote)	Name _____ Street _____ City and State _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (Go to Col. (j)) <input type="checkbox"/> No (Go to Col. (k))	<input type="checkbox"/> Yes (Go to Col. (l)) <input type="checkbox"/> No (Go to Col. (m))	<input type="checkbox"/> Yes (Go to Col. (n)) <input type="checkbox"/> No (Go to Col. (o))	<input type="checkbox"/> Yes (Go to Col. (p)) <input type="checkbox"/> No (Go to Col. (q))	<input type="checkbox"/> Yes (Go to Col. (r)) <input type="checkbox"/> No (Go to Col. (s))	<input type="checkbox"/> Yes insurance <input type="checkbox"/> Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnote)	Name _____ Street _____ City and State _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (Go to Col. (j)) <input type="checkbox"/> No (Go to Col. (k))	<input type="checkbox"/> Yes (Go to Col. (l)) <input type="checkbox"/> No (Go to Col. (m))	<input type="checkbox"/> Yes (Go to Col. (n)) <input type="checkbox"/> No (Go to Col. (o))	<input type="checkbox"/> Yes (Go to Col. (p)) <input type="checkbox"/> No (Go to Col. (q))	<input type="checkbox"/> Yes (Go to Col. (r)) <input type="checkbox"/> No (Go to Col. (s))	<input type="checkbox"/> Yes insurance <input type="checkbox"/> Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnote)	Name _____ Street _____ City and State _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (Go to Col. (j)) <input type="checkbox"/> No (Go to Col. (k))	<input type="checkbox"/> Yes (Go to Col. (l)) <input type="checkbox"/> No (Go to Col. (m))	<input type="checkbox"/> Yes (Go to Col. (n)) <input type="checkbox"/> No (Go to Col. (o))	<input type="checkbox"/> Yes (Go to Col. (p)) <input type="checkbox"/> No (Go to Col. (q))	<input type="checkbox"/> Yes (Go to Col. (r)) <input type="checkbox"/> No (Go to Col. (s))	<input type="checkbox"/> Yes insurance <input type="checkbox"/> Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnote)	Name _____ Street _____ City and State _____

TABLE B									
Col. number of person(s) with eye condition(s) reported in Table I	(READ TO RESPONDENT) Entail in the interview you told me about your eye condition. This is a matter of special interest to the Public Health Service this year and I have some additional questions about it.	Can you see well enough to read ordinary newspaper print with glasses?	Can you see well enough to recognize the features of people you know if they are close enough?	Can you see objects that move, such as cars moving or people walking?	INTERVIEWER ALL "Yes" - Ask Col. (g) and (h) ALL "No" - Fill Sect. B Supp. BOTH "Yes" and "No" - Fill Sect. A Supp.	"Yes" to Cols.(c),(d),(e)	INTERVIEWER Can you see well enough to recognize a friend walking on the other side of the street?	"No" to either Cols.(g) and (h) - STOP	"No" to either Cols.(g) and (h) - STOP
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes's (Cols. (g) & (h)) <input type="checkbox"/> No's (Sect. B Supp.) <input type="checkbox"/> Both (Sect. A Supp.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (STOP) <input type="checkbox"/> No (Ask Col. (j))	<input type="checkbox"/> Great deal <input type="checkbox"/> Some <input type="checkbox"/> Hardly any or None (STOP)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes's (Cols. (g) & (h)) <input type="checkbox"/> No's (Sect. B Supp.) <input type="checkbox"/> Both (Sect. A Supp.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (STOP) <input type="checkbox"/> No (Ask Col. (j))	<input type="checkbox"/> Great deal <input type="checkbox"/> Some <input type="checkbox"/> Hardly any or None (STOP)
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes's (Cols. (g) & (h)) <input type="checkbox"/> No's (Sect. B Supp.) <input type="checkbox"/> Both (Sect. A Supp.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (STOP) <input type="checkbox"/> No (Ask Col. (j))	<input type="checkbox"/> Great deal <input type="checkbox"/> Some <input type="checkbox"/> Hardly any or None (STOP)

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