

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: What kind of . . . is it? *For an allergy or stroke ask: How does the allergy (stroke) affect you?	Ask only for: IMPAIRMENTS, "CURRENT" INJURIES and PRESENT EFFECTS OF "OLD" INJURIES	And for: Abscesses Inflammation Aches Neuralgia Bleeding Neuritis Blood Clot Pains Boils Sores Cancer Tumors Cyst Ulcers Growth Hemorrhage Infection Weakness
(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"/>	(If 1962, 1963, or 1964 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 (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 or 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.		Line Number											
						Check one						Check one			Please look at each statement on this card. Then tell me which fits you best, in terms of health. (Show Cards D-G, as appropriate)	If "1", "2", or "3" in Col. (n) ask: Is this because of any of the conditions you have told me about?	If "Yes" in Col. (o), Col. (n) ask: Which? (Enter X on line for each condition named)								
						No (Go to Col. (e))	Yes					No (Go to Col. (f-1))	Yes					No	Yes	(e)	(f)	(g)	(h)	(i)	(j)
			Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	1
			Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	2
			Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	3
			Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	4
			Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	5

TABLE II - HOSPITALIZATIONS

Ask Col. (j) - (n) ONLY for completed hospitalizations ("No" in Col. (g)) AND delivery or operation shown in Col. (h) or Col. (i)

Ask for all hospitalizations

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?	Was any part of the surgeon's (doctor's) bill paid for by any kind of insurance?	If "No" to Col. (j), ask: Do you expect any of the surgeon's (doctor's) bill to be paid for by insurance of any kind?	Did (will) the insurance pay for 1/2 or more of the surgeon's (doctor's) bill?	Did (will) the insurance pay for 3/4 or more of the surgeon's (doctor's) bill?	What is the name of the insurance company or plan? (If unable to determine whether or not insurance, describe in footnote space below.)	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.)	Line Number
<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. (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. (m)) <input type="checkbox"/> No	<input type="checkbox"/> Yes insurance Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnotes)	Name Street City and State	1
<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. (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. (m)) <input type="checkbox"/> No	<input type="checkbox"/> Yes insurance Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnotes)	Name Street City and State	2
<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. (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. (m)) <input type="checkbox"/> No	<input type="checkbox"/> Yes insurance Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnotes)	Name Street City and State	3
<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. (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. (m)) <input type="checkbox"/> No	<input type="checkbox"/> Yes insurance Not insurance (Check one): <input type="checkbox"/> Armed Forces Medicare <input type="checkbox"/> Free care <input type="checkbox"/> Other (Specify in footnotes)	Name Street City and State	4

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) Can you see well enough to step down?	INTERVIEWER Can you see well enough to recognize a friend walking on the other side of the street?	INTERVIEWER "Yes" to both Cols. (g) and (h) - STOP "No" to either - Ask Col. (i)	"No" to either Cols.(g) or (h) How much trouble would you say that you have in seeing - a great deal, some, or hardly any at all?	Line Number
(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 (STOP) <input type="checkbox"/> No (Ask Col. (i))	<input type="checkbox"/> Great deal <input type="checkbox"/> Some <input type="checkbox"/> Hardly any or None (STOP)	(FIII Sect. A Supp.)	
		<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 (STOP) <input type="checkbox"/> No (Ask Col. (i))	<input type="checkbox"/> Great deal <input type="checkbox"/> Some <input type="checkbox"/> Hardly any or None (STOP)	(FIII Sect. A Supp.)	
		<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 (STOP) <input type="checkbox"/> No (Ask Col. (i))	<input type="checkbox"/> Great deal <input type="checkbox"/> Some <input type="checkbox"/> Hardly any or None (STOP)	(FIII Sect. A Supp.)	