

<p>1. (a) What is the name of the head of this household? (Enter name in first column) (b) What are the names of all other persons who live here? (List all persons who live here) (c) I have listed (Read names). Is there anyone else staying here now such as friends, relatives, or roomers? (d) Have I missed anyone who usually lives here but is now _____ Temporarily in a hospital? _____ _____ Away on business? _____ _____ On a visit or vacation? _____</p> <p>(e) Do any of the people in this household have a home anywhere else? <input type="checkbox"/> Yes (Apply household membership rules; if not a household member, delete) <input type="checkbox"/> No (Leave on questionnaire)</p> <p>If any adult males listed, ask: (f) Are any of the persons in this household now on full-time active duty with the Armed Forces of the United States? <input type="checkbox"/> Yes (Delete) <input type="checkbox"/> No</p>		<p>Last name ①</p> <p>First name _____</p>
2. How are you related to the head of the household? (Enter relationship to head, for example: wife, daughter, grandson, mother-in-law, partner, roomer, roomer's wife, etc.)	Relationship <input type="checkbox"/> Head	
3. How old were you on your last birthday?	Age <input type="checkbox"/> Under 1	
4. Race (Check one box for each person)	<input type="checkbox"/> White <input type="checkbox"/> Negro <input type="checkbox"/> (
5. Sex (Check one box for each person)	<input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Are you now married, widowed, divorced, separated or never married? (Check one box for each person)	<input type="checkbox"/> Und 17 yrs. <input type="checkbox"/> Never m <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed <input type="checkbox"/> Separate	
7. (a) What were you doing most of the past 12 months — (For males): working, or doing something else? (For females): keeping house, working or doing something else? If "Something else" checked, and person is 45 years old or over, ask: (b) Are you retired?	<input type="checkbox"/> Und. 17 <input type="checkbox"/> Working <input type="checkbox"/> Keeping house <input type="checkbox"/> Something else <input type="checkbox"/> Yes <input type="checkbox"/> No	
H Determine which adults are at home and record this information. Beginning with Question 8 you are to interview for himself or herself, each adult person who is at home. (If person under 19 is the respondent, check the "At home" box.)	<input type="checkbox"/> At home <input type="checkbox"/> Und. 19 <input type="checkbox"/> Not at h	
8. Were you sick at any time LAST WEEK OR THE WEEK BEFORE? (That is, the 2-week period which ended this past Sunday night.) (a) What was the matter? (b) Anything else?	<input type="checkbox"/> Yes ① <input type="checkbox"/>	
9. Last week or the week before did you take any medicine or treatment for any condition (besides ... which you told me about)? (a) For what conditions? (b) Anything else?	<input type="checkbox"/> Yes <input type="checkbox"/>	
10. Last week or the week before did you have any accidents or injuries? (a) What were they? (b) Anything else?	<input type="checkbox"/> Yes <input type="checkbox"/>	
11. Did you ever have an (any other) accident or injury that still bothers you or affects you in any way? (a) In what way does it bother you? (Record present effects) (b) Anything else?	<input type="checkbox"/> Yes <input type="checkbox"/>	
12. Has anyone in the family - you, your -, etc. - had any of these conditions DURING THE PAST 12 MONTHS? (Read Card A, condition by condition; record in his column any conditions mentioned for the person)	<input type="checkbox"/> Yes <input type="checkbox"/>	
13. Does anyone in the family have any of these conditions? (Read Card B, condition by condition; record in his column any conditions mentioned for the person)	<input type="checkbox"/> Yes <input type="checkbox"/>	
14. Do you have any other ailments, conditions, or problems with your health? (a) What is the condition? (Record condition itself if still present; otherwise record present effects.) (b) Any other problems with your health?	<input type="checkbox"/> Yes <input type="checkbox"/>	
15. (a) Have you been in a hospital at any time since _____, a year ago? If "Yes," ask: (b) How many times were you in the hospital during that period?	<input type="checkbox"/> Yes ① <input type="checkbox"/> _____ No. of times	
16. (a) Has anyone in the family been a patient in a nursing home, rest home, or any similar place since _____, a year ago? If "Yes," ask: (b) Who was this? (c) How many times were you in a nursing home or rest home during that period?	<input type="checkbox"/> Yes <input type="checkbox"/> _____ No. of time:	
R (For Q. 8-16) For persons 19 years old or over, show who responded for (or was present during the asking of) Q. 8-16. If persons responded for self, show whether entirely or partly. For persons under 19 show who responded for them.	<input type="checkbox"/> Responded for self-entirely <input type="checkbox"/> Responded for self-partly; Col. _____ was respondent	
<p>INTERVIEWER: Examine ages and relationships in Questions 2 and 3 for children one year old or under, then check the appropriate box in Question 17(a).</p>		
17. (a) <input type="checkbox"/> Baby (babies) one year or under listed. (Go to Q. 17b) <input type="checkbox"/> No baby (babies) one year or under listed. (Go to Q. 18)	(b) Are birth(s) for baby (babies) and delivery for mother shown in Table II? <input type="checkbox"/> Yes (Go to Q. 18) <input type="checkbox"/> No (Go to Q. 17(c))	
(c) Was --- born in the hospital? <input type="checkbox"/> Yes (Go to Q. 17(d)) <input type="checkbox"/> No (Go to Q. 18)	(d) When was --- born? (Enter month, day and year.) Month _____ Day _____ Year _____ (If birthdate is on or after date shown in Qs. 15 and 16, fill one line of Table II for mother at one line for child.)	

INTERVIEWER: After completing Table II for all persons, carry each condition in Col. (h) or Col. (i) back to Table I if it does not already appear there

and either { "1" or more nights in Column (f)
 OR an Impairment
 OR a Condition on Card A.

<p>18. LAST WEEK OR THE WEEK BEFORE did anyone in the family go to a dentist?</p> <p>If "Yes," ask:</p> <p>(a) Who was this?</p> <p>(b) Anyone else?</p> <p>For each person with "Yes" checked, ask:</p> <p>(c) How many times did you visit the dentist LAST WEEK OR THE WEEK BEFORE?</p> <p>(d) What did you have done (the last time, the time before, etc.)?</p> <p>(e) Anything else?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">No. of times</p> <p>(1) (2) (3)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fillings</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Extractions or other surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Straightening (Orthodontia)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Treatment for gums</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cleaning teeth</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Examination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Denture work</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (Specify) _____</p>																								
<p>If "No" to Question 18, ask:</p> <p>19. ABOUT how long has it been since you went to a dentist?</p>	<p><input type="checkbox"/> Under 6 mos. <input type="checkbox"/> 6-12 mos.</p> <p>No. of years _____ <input type="checkbox"/> Never</p>																								
<p>20. LAST WEEK OR THE WEEK BEFORE did anyone in the family talk to a doctor or go to a doctor's office or clinic?</p> <p>If "Yes," ask:</p> <p>(a) Who was this?</p> <p>(b) Anyone else?</p> <p>For EACH person with "Yes" box checked, ask Questions 20(c) through (f):</p> <p>(c) How many times did you see or talk to a doctor LAST WEEK?</p> <p>(d) How many times did you see or talk to a doctor the WEEK BEFORE LAST?</p> <p>Ask for EACH visit to a doctor in last 2 weeks:</p> <p>(e) Where did you talk to the doctor (the last time, the time before, etc.)?</p> <p>(f) Why did you go to (call) the doctor (that time)?</p>	<p style="text-align: center;">INTERVIEWER: DO NOT COUNT doctors seen while an inpatient in a hospital</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Place</th> <th style="width:50%;">Purpose</th> </tr> </thead> <tbody> <tr> <td>Home = At home</td> <td>D/T = Diag. or treat-ment</td> </tr> <tr> <td>Off. = At office</td> <td>Not. = Pre/post natal care</td> </tr> <tr> <td>Clin. = Outpatient Hospital Clinic</td> <td>Gen. = Gen'l check-up</td> </tr> <tr> <td>Co. = Company or industry</td> <td>I/V = Immun./Vacc. (glasses)</td> </tr> <tr> <td>Tel. = Over telephone</td> <td>Eye = Eye Exam. (glasses)</td> </tr> <tr> <td>Ot. = Other (Specify)</td> <td>Ot. = Other (Specify)</td> </tr> </tbody> </table>	Place	Purpose	Home = At home	D/T = Diag. or treat-ment	Off. = At office	Not. = Pre/post natal care	Clin. = Outpatient Hospital Clinic	Gen. = Gen'l check-up	Co. = Company or industry	I/V = Immun./Vacc. (glasses)	Tel. = Over telephone	Eye = Eye Exam. (glasses)	Ot. = Other (Specify)	Ot. = Other (Specify)										
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<p>If "No" to Question 20, ask:</p> <p>21. ABOUT how long has it been since you have seen or talked to a doctor?</p>	<p><input type="checkbox"/> Under 6 mos. <input type="checkbox"/> 6-12 mos.</p> <p>No. of years _____ <input type="checkbox"/> Never</p>																								
<p>If any children under 17 years in household, ask:</p> <p>22. DURING THE PAST 12 MONTHS was--(were --, --, etc.) taken to a doctor for a ROUTINE physical examination, that is, not for a particular illness but for a general check-up?</p> <p>If "Yes," and more than one child under 17 years, ask:</p> <p>(a) Who was this?</p> <p>(b) Any of the other children?</p>	<p style="text-align: center;">①</p> <p><input type="checkbox"/> 17 years or over</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																								
<p>23. DURING THE PAST 12 MONTHS has ANYONE in the family -- that is, you, your --, etc., -- received any services from any of the persons listed on this card? Please check "Yes" or "No" for each one listed.</p> <p>Hand respondent pencil and card (NHS-HIS-1(a))</p> <p>For each "Yes" box checked on the card, ask:</p> <p>(a) Who saw the (specialist)? (Mark (X) for each specialist in person's column.)</p> <p>(b) About how many times did you see a (specialist) during the past 12 months (not counting any visits while you were in the hospital)?</p> <p>(c) Did anyone else see a (specialist) during the past 12 months?</p> <p>If "Yes," ask:</p> <p>(d) Who was this?</p> <p>(e) About how many times did you see a (specialist) during the past 12 months (not counting any visits while you were in the hospital)?</p> <p><i>Check the "None" box for each person who did not see a specialist.</i></p>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;">(Mark (X) Specialist)</th> <th style="width:20%;">Times</th> </tr> </thead> <tbody> <tr><td>Pediatrician</td><td>A</td></tr> <tr><td>Obstetrician or Gynecologist</td><td>B</td></tr> <tr><td>Ophthalmologist</td><td>C</td></tr> <tr><td>Otolaryngologist</td><td>D</td></tr> <tr><td>Psychiatrist</td><td>E</td></tr> <tr><td>Dermatologist</td><td>F</td></tr> <tr><td>Orthopedist</td><td>G</td></tr> <tr><td>Chiropractor</td><td>H</td></tr> <tr><td>Optometrist</td><td>I</td></tr> <tr><td>Podiatrist or Chiropractor</td><td>J</td></tr> <tr><td colspan="2" style="text-align: center;"><input type="checkbox"/> None</td></tr> </tbody> </table>	(Mark (X) Specialist)	Times	Pediatrician	A	Obstetrician or Gynecologist	B	Ophthalmologist	C	Otolaryngologist	D	Psychiatrist	E	Dermatologist	F	Orthopedist	G	Chiropractor	H	Optometrist	I	Podiatrist or Chiropractor	J	<input type="checkbox"/> None	
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<p>If male and 17 years old or over, ask:</p> <p>24. (a) Did you ever serve in the Armed Forces of the United States?</p> <p>If "Yes," ask:</p> <p>(b) Was any of your service during a war or was it peace-time only?</p> <p>If "War," ask:</p> <p>(c) During which war did you serve?</p> <p>If "Peace-time only," ask:</p> <p>(d) Was any of your service between June 27, 1950 and January 31, 1955?</p>	<p><input type="checkbox"/> Fem. or under 17 years</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> War <input type="checkbox"/> Peace-time only</p> <p><input type="checkbox"/> WW II <input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																								
<p>If 17 years old or over, ask:</p> <p>25. (a) What is the highest grade you attended in school?</p> <p>(Circle highest grade attended or check "None")</p> <p>(b) Did you finish the -- grade (year)?</p>	<p style="text-align: center;">Under 17 years</p> <p>Elem: 1 2 3 4 5 6 7 8</p> <p>High: 1 2 3 4</p> <p>College: 1 2 3 4 5+</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																								
<p>Ask for all persons 17 years old or over:</p> <p>26. (a) Did you work at any time last week or the week before?</p> <p>If "No," ask BOTH 26(b) and 26(c):</p> <p>(b) Even though you did not work last week or the week before do you have a job or business?</p> <p>(c) Were you looking for work or on layoff from a job?</p>	<p style="text-align: center;">Under 17 years</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																								
<p>27. Which of these income groups represents your total combined family income for the past 12 months, that is, your's, your--'s, etc.? (Show Card H). Include income from all sources, such as wages, salaries, rents from property, social security or retirement benefits, help from relatives, etc.</p>	<p>Group ①</p>																								
<p>T INTERVIEWER: Enter the total number of hospitalizations for each person from Questions 15 and 16, or check the "None" box. Fill one line of Table II for each separate stay in the hospital.</p>	<p>Total No. of hospitalizations</p> <p>_____ or <input type="checkbox"/> None</p>																								

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. 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. (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)	Line Number		
						Check one										Did it start (happen) during the past 2 weeks or before that time? (If during past 2 weeks, ask: Which week, last week, or the week before?)	If Col. (k-1) is checked, or the condition is on Card A or is an impairment; otherwise, STOP (aa)
						Check one	Check one										
No (Go to Col. (e))	Yes	No (Go to Col. (f-1))	Yes (f-2)	No	Yes	Before 3 mos. (Go to Col. (k-4))	During 3 mos.	(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"/>			<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	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<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"/>			<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	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<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"/>			<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	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<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"/>			<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	Days <input type="checkbox"/> None <input type="checkbox"/>	Days <input type="checkbox"/> None <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		4			
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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 <input type="checkbox"/> No	<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 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 <input type="checkbox"/> No	<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 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 <input type="checkbox"/> No	<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 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 <input type="checkbox"/> No	<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 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.)	

<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>