

Table I - ILLNESSES, IMPAIRMENTS, AND INJURIES										
Line number	Col. No. of person	Question No.	Did you ever AT ANY TIME talk to a doctor about your ...?	If condition is on Card C, enter condition without asking columns (d-1) through (d-4) and go to columns (e)-(f). For all other illnesses and present effects of "old" injuries - - If doctor talked to, ask: What did the doctor say it was - did he give it a medical name? - If doctor NOT talked to, record original entry and ask (d-2) - (d-4) as required. For all injuries which happened LAST WEEK OR THE WEEK BEFORE, ask: What part of the body was hurt? What kind of injury was it? (For injuries or accidents which happened before the past 2 weeks, enter the present effects.)	CAUSE	KIND	PART OF BODY	LAST WEEK OR THE WEEK BEFORE did you ... cause you to cut down on the things you usually do?	Did you have to cut down for as much as a day?	
					If the entry in col. (d-1) is An IMPAIRMENT or a SYMPTOM or came from Question 9 or 11, ask: What was the cause of ...? (If "Cause" is an injury, enter "Accident" or "Injury" and 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: Abscess Inflammation Ache (except head) Neuritis Bleeding Pain Blood clot Sore Boil Soreness Cancer Tumor Cyst Ulcer Growth Weak Hemorrhage Weakness Infection 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)			(Check one)
(a)	(b)	(c)	(d-1)	(d-2)	(d-3)	(d-4)	(e)	(f)	(g)	(h)
6			<input type="checkbox"/> Yes <input type="checkbox"/> No							
7			<input type="checkbox"/> Yes <input type="checkbox"/> No							
8			<input type="checkbox"/> Yes <input type="checkbox"/> No							

Table II - HOSPITALIZATIONS									
INTERVIEWER: Enter TOTAL number of hospitalizations recorded in question 13.  (Number)	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 cols. (c) and (d); or, if not clear ask the questions. How many of these - - nights were in the past 12 months?	How many of these - - nights were last week or the week before?		Were you still in the hospital last Sunday night?
(Number)	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	
Fill one line of Table II for each hospital stay reported. If no hospitalizations reported, check the "None" box.  <input type="checkbox"/> None	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	

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	Part(s) of body		Kind of injury (injuries)					
Accident happened last week or week before (Go to Q. 3)	<input type="checkbox"/>	(If 1963, 1964, or 1965 also enter month):	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 (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?	<input type="checkbox"/> At home (inside house) <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? <input type="checkbox"/> Street and highway (includes roadway) <input type="checkbox"/> School (includes school premises) <input type="checkbox"/> Farm <input type="checkbox"/> Place of recreation and sports, except at school <input type="checkbox"/> Industrial place (includes premises) <input type="checkbox"/> Other (Specify the place where accident happened) _____								
5. Were you at work at your job or business when the accident happened?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> While in Armed Services <input type="checkbox"/> Under 17 at time of accident								
INTERVIEWER: Return to Table I and complete the rest of this line.									

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

How many days did you have to cut down 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 during that two week period?	If "Yes" in Q. 5a or 5b, ask: How many days did you keep you from work during that two week period?	Did you first notice your . . . (did it happen) during the past 3 months or before that time?		If col. (m) is checked, ask: Did you first notice it during the past 12 months or before that time?	To Interviewer CONTINUE if col. (m) 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 your . . . kept you in bed all or most of the day?	If 1 or more days in col. (q) and col. (j) is blank or checked "None," ask: Were any of these -- days during last week or the week before? If "Yes," ask: How many?	If "Yes" to col. (c), ask: ABOUT how many times during the past 12 months have you seen or talked to a doctor about your . . . ?	Ask after completing last condition for each person.				Line number	
				Before 3 months (Go to col. (p))	During 3 mos. (p)						Did you first notice it (did it happen) during the past 2 weeks or before that time? If "During past 2 weeks," ask: Which week, last week or the week before?	3-12 mos. Before 12 mos.	Days or None	Days or None		Times or None
(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(a)	(q)	(r)	(s)	(t)	(u)	(v)	(w)	
Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None			<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 mos. <input type="checkbox"/> Before 12 mos.		Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Times <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		6
Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None			<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 mos. <input type="checkbox"/> Before 12 mos.		Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Times <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		7
Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Days <input type="checkbox"/> None			<input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> Before 2 wks.	<input type="checkbox"/> 3-12 mos. <input type="checkbox"/> Before 12 mos.		Days <input type="checkbox"/> None	Days <input type="checkbox"/> None	Times <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		8

**Table II - 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?	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	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 there are "1" or more nights in col. (f) OR the entry in col. (h) or col. (i) is an "Impairment" OR a condition on Card A.
(i)	(j)		
<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	

<p><b>Card A</b></p> <p style="text-align: center;"><b>Check List of Chronic Conditions</b></p> <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> <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 E</b></p> <p><b>For: 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 the above ways.</li> </ol>	<p><b>Card G</b></p> <p><b>For: 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 the above ways.</li> </ol>	<p><b>Card I</b></p> <p><b>For: Mobility</b></p> <ol style="list-style-type: none"> <li>1. Must stay in bed all or most of the time.</li> <li>2. Must stay in the house all or most of the time.</li> <li>3. Need the help of another person in getting around inside or outside the house.</li> <li>4. Need the help of some special aid, such as a cane or wheelchair, in getting around inside or outside the house.</li> <li>5. Not limited in any of the above ways.</li> </ol>
<p><b>Card B</b></p> <p style="text-align: center;"><b>Check List of Selected Impairments</b></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 F</b></p> <p><b>For: 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 the above ways.</li> </ol>	<p><b>Card H</b></p> <p><b>For: 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 the above ways.</li> </ol>	<p><b>Card K</b></p> <p><b>For: Total combined family income during past 12 months</b></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>