

HOSPITAL PAGE		1. Person number Write in and mark								
Enter month, day, year; if the exact date is not known, obtain the best estimate. USE YOUR CALENDAR	You said that -- was in the hospital (once, twice; etc.) during the past year: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Month</td></tr> <tr><td>Day</td></tr> <tr><td>Year</td></tr> </table>		Month	Day	Year	WASHINGTON USE Month } Jan <input type="checkbox"/> Apr <input type="checkbox"/> July <input type="checkbox"/> Oct <input type="checkbox"/> } Feb <input type="checkbox"/> May <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> } Mar <input type="checkbox"/> June <input type="checkbox"/> Sept <input type="checkbox"/> Dec <input type="checkbox"/> Day } Year }				
	Month									
Day										
Year										
2. When did -- enter the hospital (the last time)? Write in: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Month</td></tr> <tr><td>Day</td></tr> <tr><td>Year</td></tr> </table> Make sure the YEAR is correct.		Month	Day	Year						
Month										
Day										
Year										
Do not include any nights in interview week. If the exact number is not known, accept the best estimate.	3. How many nights was -- in the hospital? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Total nights in hospital</td></tr> </table>		Total nights in hospital	Nights						
Total nights in hospital										
Complete question 4 from entries in questions 2 and 3; if not clear, ask the questions. Do not include any nights in interview week. USE YOUR CALENDAR	4a. How many of these -- nights were in the past 12 months? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Nights in past 12 months</td></tr> </table>		Nights in past 12 months	Q. No. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>13</td> <td>14</td> <td>Other</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	13	14	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nights in past 12 months									
13	14	Other								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
4b. How many of these -- nights were last week or the week before? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Nights past 2 weeks</td></tr> </table>		Nights past 2 weeks	Drag.							
Nights past 2 weeks										
4c. Was -- still in the hospital last Sunday night for this hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No		Diagnosis surgically treated								
Ask for all hospitalizations. If medical name not known, enter an adequate description. Entry must show CAUSE, KIND, and PART OF BODY in same detail as required for the Condition page.	5. For what condition did -- enter the hospital, do you know the medical name? For delivery ask: Was this a normal delivery? * For newborn, ask: Was the baby normal at birth? * *If "No" ask: What was the matter? (Record in "Condition" box) <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Condition</td></tr> </table>		Condition	Operation 1						
	Condition									
6a. Were any operations performed on -- during this stay at the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No - Go to 7		Operation 2								
If name of operation is not known, describe what was done.	b. What was the name of the operation? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Operation</td></tr> </table>		Operation	Operation 3						
	Operation									
c. Any other operations? <input type="checkbox"/> Yes - Describe above <input type="checkbox"/> No		Service								
Enter the full name of the hospital, the street or highway on which it is located, and the city and State; if the city is not known, enter the county.	7. What is the name and address of the hospital? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>Name of Hospital</td></tr> <tr><td>Address</td></tr> <tr> <td>City (or county)</td> <td>State</td> </tr> </table>		Name of Hospital	Address	City (or county)	State	Ownership			
	Name of Hospital									
Address										
City (or county)	State									
IF THE CONDITION IN QUESTION 5 OR 6 INDICATES THAT AN ACCIDENT OR INJURY WAS INVOLVED, FILL QUESTIONS 8 - 11		When accident happened								
8a. Did the accident happen during the past 2 years or before that time? <input type="checkbox"/> During the past 2 years <input type="checkbox"/> Before 2 years (6) - Go to 9a		Oth. Acc. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>T-Mis.</td> <td>Other</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		T-Mis.	Other	<input type="checkbox"/>	<input type="checkbox"/>			
T-Mis.	Other									
<input type="checkbox"/>	<input type="checkbox"/>									
b. When did the accident happen? Enter month and year, mark one circle. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>Month</td> <td>Year</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Month	Year	<input type="checkbox"/>	<input type="checkbox"/>	IC or dwn. code				
Month	Year									
<input type="checkbox"/>	<input type="checkbox"/>									
c. 1 - 2 years (6) <input type="checkbox"/> Last week (0) <input type="checkbox"/> Week before (1) <input type="checkbox"/> 2 weeks - 3 months (2) <input type="checkbox"/> 3 - 12 months (4)		9a. Was a car, truck, bus or other motor vehicle involved in the accident in any way? Yes No - Go to 11 V <input type="checkbox"/> Yes <input type="checkbox"/> No								
9b. Was more than one vehicle involved? Yes No <input type="checkbox"/> Yes <input type="checkbox"/> No		9c. Was it (either one) moving at the time? Yes No V <input type="checkbox"/> Yes <input type="checkbox"/> No								
10. Where did the accident happen? <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>(Specify place)</td></tr> </table>		(Specify place)	At home (inside home) <input type="checkbox"/> At home (adjacent premises) <input type="checkbox"/> Street and highway (includes roadway) <input type="checkbox"/> Farm <input type="checkbox"/> Industrial place (includes premises) <input type="checkbox"/> School (includes school premises) <input type="checkbox"/> Place of recreation and sports (not school) <input type="checkbox"/> Other (Specify place where accident happened) <input type="checkbox"/> V							
(Specify place)										
NOTE TO INTERVIEWER: If the condition in question 5 or 6 is on Card A or B or there are "1" or more nights in question 4b, the condition must have a completed Condition page. If the condition does not have a Condition page, fill one after completing all required Hospitalization pages.		11. Was -- at work at his job or business when the accident happened? Yes No Under 17 While in Armed Forces V <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Under 17 <input type="checkbox"/> While in Armed Forces								