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CONDITION NO. 1	1. Person number Write in and mark <input style="width: 40px; height: 20px;" type="text"/>	Person number 0 1 2 0 1 2 3 4 5 6 7 8 9
Enter person number and "name of condition" and ask question 2.	Name of condition	
Ask for all conditions	2. DID -- EVER AT ANY TIME TALK TO A DOCTOR ABOUT HIS ...? Yes No V O O O O O	
Examine "Name of condition" entry in Item 1 and mark one box.	<input type="checkbox"/> Accident or injury-Go to 4 <input type="checkbox"/> Condition on Card C-Go to 9 <input type="checkbox"/> Neither Go to 3a.	WASHINGTON USE Question number 8 9 10 11 12 13 14 H C DV HC OT O O O O O O O O O O O O O O
If "Doctor talked to", ask: If "Doctor not talked to" record adequate description of condition or illness.	3a. WHAT DID THE DOCTOR SAY IT WAS? DID HE GIVE IT A MEDICAL NAME?	Cond. } 0 1 2 3 4 5 6 7 8 9 } 0 1 2 3 4 5 6 7 8 9 } 0 1 2 3 4 5 6 7 8 9 } 0 1 2 3 4 5 6 7 8 9
	3b. WHAT WAS THE CAUSE OF ...? <input type="checkbox"/> Accident or injury Go to 4	
If the entry in 3a or 3b includes the words: Asthma "Ailment" "Disease" Cyst "Attack" "Disorder" Growth "Condition" "Trouble" Measles "Defect" Tumor	3c. WHAT KIND OF ... IS IT? Ask:	No. of this condition 1 2 3 4 5 6 7 8 9 Mark one Chronic Acute O O
For ALLERGY OR STROKE, Ask:	3d. HOW DOES THE ALLERGY (STROKE) AFFECT HIM?	Total conditions 1 2 3 4 5 6 7 8 9 Accident First injury code Yes No O O Required hospitalization Yes No O O Other Acc. T.Mis. Ch. O O
For conditions on Card B-2 and for any entry that includes the words: Abscess Cyst Paralysis Ache (except headache) Growth Sore Hemorrhage Soreness Bleeding Infection Tumor Blood clot Inflammation Ulcer Boil Neuralgia Weak Cancer Neuritis Weakness Cramps (except menstrual) Pain Weakness Palsy	3e. WHAT PART OF THE BODY IS AFFECTED? SHOW THE FOLLOWING DETAIL: 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	IC or dum code. 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 Person days of disability V R.A. } 0 1 2 3 4 5 6 7 8 9 O O O O O O O O O O 2Wks. B.D. } 0 1 2 3 4 5 6 7 8 9 O O O O O O O O O O Under 6 V T.L. } 0 1 2 3 4 5 6 7 8 9 O O O O O O O O O O 12 Months B.D. } 0 1 2 3 4 5 6 7 8 9 O O O O O O O O O O
FILL QUESTIONS 4-8 FOR ALL ACCIDENTS OR INJURIES		
4a. DID THE ACCIDENT HAPPEN DURING THE PAST 2 YEARS OR BEFORE THAT TIME? During past 2 years-Ask 4b Before 2 years-Go to 5a	6a. WAS A CAR, TRUCK, BUS, OR OTHER MOTOR VEHICLE INVOLVED IN THE ACCIDENT IN ANY WAY? Yes No-Go to 7 V O O O	
4b. WHEN DID THE ACCIDENT HAPPEN? Enter month and year; mark one box Month <input style="width: 40px; height: 20px;" type="text"/> Year <input style="width: 40px; height: 20px;" type="text"/> <input type="checkbox"/> Last week <input type="checkbox"/> Week before <input type="checkbox"/> 2 weeks - 3 months <input type="checkbox"/> 3 - 12 months <input type="checkbox"/> 1 - 2 years	b. WAS MORE THAN ONE VEHICLE INVOLVED? Yes No O O c. WAS IT (EITHER ONE) MOVING AT THE TIME? Yes No V O O O	
Ask for all accidents or injuries: 5a. AT THE TIME OF THE ACCIDENT WHAT PART OF THE BODY WAS HURT? WHAT KIND OF INJURY WAS IT? ANYTHING ELSE? Part(s) of body Kind of injury(injuries) ----- ----- ----- -----	7. WHERE DID THE ACCIDENT HAPPEN? Specify place <input type="checkbox"/> At home (inside house) <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) V O	
If accident happened BEFORE 3 months, ask: 5b. WHAT PART OF THE BODY IS AFFECTED NOW? HOW IS HIS -- AFFECTED? Part(s) of body Present effects ----- ----- -----	8. WAS -- AT WORK AT HIS JOB OR BUSINESS WHEN THE ACCIDENT HAPPENED? Yes No Under 17 While in Armed Forces V O O O O O	
Footnotes		
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<p>Card A</p> <p>A--1 Now I'm going to read a list of conditions--Please tell me if you, your , etc., have had any of these conditions DURING THE PAST 12 MONTHS?</p> <ol style="list-style-type: none"> 1. Asthma? 2. CHRONIC bronchitis? 3. REPEATED attacks of sinus trouble? 4. TROUBLE with varicose veins? 5. Hemorrhoids or piles? 6. Hay fever? 7. Tumor, cyst, or growth? 8. CHRONIC gallbladder or liver trouble? 9. Stomach ulcer? 10. Any other CHRONIC stomach trouble? 11. Kidney stones or CHRONIC kidney trouble? 	<p>A--2 Have you, your , etc., had any of these conditions DURING THE PAST 12 MONTHS?</p> <ol style="list-style-type: none"> 12. Thyroid trouble or goiter? 13. Any allergy? 14. CHRONIC nervous trouble? 15. CHRONIC skin trouble? 16. Palsy? 17. Paralysis of any kind? 18. REPEATED trouble with back or spine? 19. Cleft palate? 20. Any speech defect? 21. Hernia or rupture? 22. Prostate trouble? 	<p>Card D</p> <p>For: 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 the above ways. 	<p>Card F</p> <p>For: 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 the above ways. 	<p>Card H</p> <p>For: Mobility</p> <ol style="list-style-type: none"> 1. Must stay in bed all or most of the time. 2. Must stay in the house all or most of the time. 3. Need the help of another person in getting around inside or outside the house 4. Need the help of some special aid, such as a cane or wheelchair, in getting around inside or outside the house. 5. Does not need the help of another person or a special aid but has trouble in getting around freely. 6. Not limited in any of the above ways.
<p>Card B</p> <p>B--1 Have you, your , etc., EVER had any of these conditions?</p> <ol style="list-style-type: none"> 1. Tuberculosis? 2. Emphysema? 3. Hardening of the arteries? 4. High blood pressure? 5. Cancer? 6. Heart trouble? 7. Stroke? 8. Rheumatic fever? 9. Arthritis or rheumatism? 10. Mental illness? 11. Diabetes? 12. Epilepsy? 	<p>B--2 Do you, your , etc., 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. Missing fingers, hand or arm -- toes, foot or leg? 4. Missing lung or kidney (or breast)? 5. Club foot? 6. PERMANENT stiffness or any deformity of foot, leg, fingers, arm or back? 	<p>Card E</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 the above ways. 	<p>Card G</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 the above ways. 	<p>Card I</p> <p>Which of the following income groups represents your total combined family income for the past 12 months? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rents from property, and so forth.</p> <p>Under \$500 Group A</p> <p>\$500-- \$999 Group B</p> <p>\$1,000-- \$1,999 Group C</p> <p>\$2,000-- \$2,999 Group D</p> <p>\$3,000-- \$3,999 Group E</p> <p>\$4,000-- \$4,999 Group F</p> <p>\$5,000-- \$6,999 Group G</p> <p>\$7,000-- \$9,999 Group H</p> <p>\$10,000--\$14,999 Group I</p> <p>\$15,000 and over Group J</p>