

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CONDITION NO. _____ | 1. Person number _____ |
| 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 . . . ? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| Examine "Name of condition" entry in Item 1 and mark | <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 |
| 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? <input type="checkbox"/> Accident or injury - Go to 4 |
| Do not ask for Cancer | 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 Measles "Ailment" Cyst Rupture "Attack" Growth Tumor "Defect" Hernia Ulcer "Disease" "Disorder" "Trouble" | 3c. What kind of . . . is it? <input type="checkbox"/> Accident or injury - Go to 4 |
| For ALLERGY OR STROKE, ask: | 3d. How does the ALLERGY (STROKE) affect him? |
| For any entry that includes the words: Abscess Inflammation Ache (except Neuralgia headache) Neuritis Bleeding Pain Blood clot Palsy Boil Paralysis Cancer Rupture Cramps (except Sore menstrual) Soreness Cyst Tumor Damage Ulcer Growth Weak Hemorrhage Weakness Infection Weakness | 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 |
| For person 6 years old or over | 3f. Can -- see well enough to read ordinary newspaper print with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| FILL QUESTIONS 4-8 FOR ALL ACCIDENTS OR INJURIES | |
| 4a. Did the accident happen during the past 2 years or before that time? <input type="checkbox"/> During past 2 years - Ask 4b <input type="checkbox"/> Before 2 years - Go to 5a | 6a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? 1 <input type="checkbox"/> Yes - Ask b 2 <input type="checkbox"/> No - Go to 7 |
| 4b. When did the accident happen? Enter month and year; mark one box Month _____ Year _____ <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? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ask for all accidents or injuries: | c. Was it (either one) moving at the time? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 5a. At the time of the accident what part of the body was hurt? What kind of injury was it? Anything else? | 7. Where did the accident happen? 1 <input type="checkbox"/> At home (inside house) 2 <input type="checkbox"/> At home (adjacent premises) 3 <input type="checkbox"/> Street and highway (includes roadway) 4 <input type="checkbox"/> Farm 5 <input type="checkbox"/> Industrial place (includes premises) 6 <input type="checkbox"/> School (includes premises) 7 <input type="checkbox"/> Place of recreation and sports, except at school 8 <input type="checkbox"/> Other - Specify the place where accident happened |
| Part(s) of body _____ Kind of injury _____ | |
| Part(s) of body _____ Kind of injury _____ | |
| Part(s) of body _____ Kind of injury _____ | |
| Part(s) of body _____ Kind of injury _____ | |
| Part(s) of body _____ Kind of injury _____ | |
| If accident happened BEFORE 3 months, ask: 5b. What part of the body is affected now? How is his -- affected? | 8. Was -- at work or at his 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 |
| Part(s) of body _____ Present effects _____ | |
| Part(s) of body _____ Present effects _____ | |
| Part(s) of body _____ Present effects _____ | |
| Part(s) of body _____ Present effects _____ | |
| Part(s) of body _____ Present effects _____ | |

| WASHINGTON USE | |
|-------------------------------------------------------------------------------|-------|
| Question number | _____ |
| Condition diag. code | _____ |
| Number of this condition | _____ |
| 1 <input type="checkbox"/> Chronic 2 <input type="checkbox"/> Acute | |
| Total conditions | _____ |
| Accident | |
| 1st inj. X <input type="checkbox"/> Yes 0 <input type="checkbox"/> No | |
| Req. hosp. X <input type="checkbox"/> Yes 0 <input type="checkbox"/> No | |
| Other accident | |
| Ther. mis. 1 <input type="checkbox"/> 2 <input type="checkbox"/> | |
| I.C. or Dum. code | _____ |
| Cause of limitation | _____ |

| | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ask question 9a for all conditions. | 9a. During the past two weeks, did his . . . cause him to cut down on the things he usually does? b. Did he have to cut down for as much as a day? | <input type="checkbox"/> Yes <input type="checkbox"/> No - Go to 14a <input type="checkbox"/> Yes <input type="checkbox"/> No - Go to 14a |
| Ask questions 10 and 11 if "Yes" marked in question 9b. | 10. How many days did he have to cut down during that two-week period? 11. During that two-week period, how many days did his . . . keep him in bed all or most of the day? | ____ Days ____ Days <input type="checkbox"/> None |
| Ask question 12 if person is 6-16 years old. | 12. How many days did his . . . keep him from school during that two-week period? | ____ Days <input type="checkbox"/> None |
| Ask question 13 if person is 17 years old or over. | 13. How many days did his . . . keep him from work during that two-week period? (For females add) not counting work around the house? | ____ Days <input type="checkbox"/> None |
| Ask question 14 for all conditions. | 14a. When did he first notice his . . . ? Was it during the past 3 months or before that time? b. Did he first notice it during the past two weeks or before that time? c. Which week, last week or the week before? | 2 <input type="checkbox"/> During 3 months 6 <input type="checkbox"/> Before 3 months - Go to 15 <input type="checkbox"/> Past 2 weeks 3 <input type="checkbox"/> Before 2 weeks - Go to AA 0 <input type="checkbox"/> Last week } Go to AA 1 <input type="checkbox"/> Week before } |
| Ask question 15 only if condition was first noticed "Before 3 months." | 15. Did -- first notice it during the past 12 months or before that time? | 4 <input type="checkbox"/> 3 - 12 months 5 <input type="checkbox"/> Before 12 months |
| AA: Continue if this condition started "Before 3 months" or is in this list: Cancer, any kind Diverticulitis Gallstones Piles Cirrhosis of the liver Enteritis Hemorrhoids Rupture, any kind Colitis Fatty liver Hernia, any kind Spastic colon Ulcer, any kind STOP for all other conditions and for accidents, injuries, and pregnancies. | | |
| <input type="checkbox"/> "Doctor not seen" in question 2 - Ask question 16 <input type="checkbox"/> "Doctor seen" in question 2 - Ask question 17 | | |
| Ask if "Doctor not seen" in question 2. | 16. During the past 12 months what did -- do or take for his . . . ? | Go to 24 |
| Ask if "Doctor seen" in question 2. | 17. Before -- first talked to a doctor about his . . . , what did he do or take for this condition? 18. Before -- first talked to a doctor about this condition, what kind of symptoms did he have? 19. About how long did -- have any of these symptoms before he talked to a doctor about them? 20. Does -- take any medicine or treatment which a doctor advised for his . . . ? 21. Has -- ever had surgery for . . . ? 22. Was -- ever hospitalized for . . . ? 23. During the past 12 months about how many times has -- seen or talked to a doctor for this condition? | <input type="checkbox"/> None - Go to 20 ____ day(s) ____ month(s) ____ week(s) ____ year(s) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No ____ Times <input type="checkbox"/> None |
| Ask for all conditions past AA. | 24. About how many days during the past 12 months, has his . . . kept him in bed all or most of the day? 25a. Does his . . . bother him - a great deal, some, very little, or not at all? For "Other" answers: If "not bothered at all" ask b, otherwise go to next condition b. Does -- still have this condition? c. Is this condition completely cured or is it under control? d. About how long did -- have this condition? | ____ Days <input type="checkbox"/> None <input type="checkbox"/> Great deal } Go to next condition <input type="checkbox"/> Some } <input type="checkbox"/> Very little } <input type="checkbox"/> Not at all - Ask b <input type="checkbox"/> Other 1 <input type="checkbox"/> Yes - Go to next person <input type="checkbox"/> No - Ask c <input type="checkbox"/> Cured-As/ of 2 <input type="checkbox"/> Und. control <input type="checkbox"/> Other - Specify ____ month(s) ____ year(s) |