

CONDITION 1		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 (4) <input type="checkbox"/> Condition on Card C (9) <input type="checkbox"/> Neither (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?		WASHINGTON DEL. Question No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
Do not ask for Cancer.	b. What was the cause of . . . ? <input type="checkbox"/> Accident or injury (4)		Condition diag. code				
If the entry in 3a or 3b includes the words: Asthma      "Allment" Cyst          "Attack" Growth      "Condition" Measles     "Defect" Rupture     "Disease" Tumor       "Disorder" Ulcer        "Trouble"	c. What kind of . . . is it?		Number of this condition				
			1 <input type="checkbox"/> Chronic    2 <input type="checkbox"/> Acute				
For ALLERGY OR STROKE, ask:	d. How does the ALLERGY (STROKE) affect him?		Total conditions				
For any entry that includes the words: Abscess      Inflammation Ache(except headache)    Neuralgia Bleeding      Neuritis Blood clot    Pain Bull            Palsy Cancer        Paralysis Cramps (except menstrual)    Rupture Cyst            Sore Damage        Soreness Growth        Tumor Hemorrhage    Ulcer Infection      Varicose veins Weak Weakness	e. What part of the body is affected?		Accident - 1st injury				
	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		1 <input type="checkbox"/> Yes    2 <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 (4b) <input type="checkbox"/> Before 2 years (5a)					
b. When did the accident happen? Enter month and year: Mark one box.		<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					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Month</td> <td style="width: 50%;">Year</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>		Month	Year				
Month	Year						
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?		6a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way?					
Part(s) of body		1 <input type="checkbox"/> Yes (6b)    2 <input type="checkbox"/> No (7)					
Kind of injury		b. Was more than one vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		c. Was it (either one) moving at the time?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No					
If accident happened BEFORE 3 months, ask:		7. Where did the accident happen?					
b. What part of the body is affected now? How is his --- affected? Is he affected in any other way?		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		8. Was --- at work at his job or business when the accident happened?					
Present effects		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					

Mark for all conditions	9. <input type="checkbox"/> Not an eye cond. (10a) <input type="checkbox"/> First eye cond. (9a)	9a. Can --- see well enough to read ordinary newspaper print with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Under 6 (10a) <input type="checkbox"/> Not first eye cond. (10a)		
10a. During the past two weeks, did his . . . cause him to cut down on the things he usually does?		<input type="checkbox"/> Yes <input type="checkbox"/> No (15a)	
b. Did he have to cut down for as much as a day?		<input type="checkbox"/> Yes <input type="checkbox"/> No (15a)	
11. How many days did he have to cut down during that 2-week period?		___ Days	
12. During that 2-week period, how many days did his . . . keep him in bed all or most of the day?		___ Days 00 <input type="checkbox"/> None	
13. Ask if 6 - 16 years: How many days did his . . . keep him from school during that 2-week period?		___ Days (15a) 00 <input type="checkbox"/> None (15a)	
14. Ask if 17+ years: How many days did his . . . keep him from work during that 2-week period? (For females): not counting work around the house?		___ Days 00 <input type="checkbox"/> None	
15a. When did he first notice his . . . ? - Was it during the past 3 months or before that time?		<input type="checkbox"/> During 3 mos. (15b) <input type="checkbox"/> More than 3 mos. ago (16)	
b. Did he first notice it during the past two weeks or before that time?		<input type="checkbox"/> Past 2 weeks (15c) 4 <input type="checkbox"/> More than 2 wks. ago (AA)	
c. Which week, last week or the week before?		1 <input type="checkbox"/> Last week 2 <input type="checkbox"/> Wk before } (AA)	
16. Did --- first notice it during the past 12 months or before that time?		5 <input type="checkbox"/> 3-12 months 6 <input type="checkbox"/> More than 12 mos. ago	
AA	Continue if $\left\{ \begin{array}{l} \text{reported in probe Q. 16} \\ \text{reported in probe Q. 25} \\ \text{on Card D} \end{array} \right\}$ Otherwise, go to next condition		
<b>INTERVIEWER CHECK ITEM</b> <input type="checkbox"/> "Yes" in question 2 (18) <input type="checkbox"/> "No" in question 2 (17)			
17. During the past 12 months what did --- do or take for his . . . ? Anything else? Write in _____		(24)	
18. After --- first noticed something was wrong, how long was it before he talked to a doctor about it? (Estimate is acceptable)		0 <input type="checkbox"/> Discovered by doctor (20) 2 ___ Days 4 ___ Months 3 ___ Weeks 5 ___ Years	
19. Before --- talked to a doctor about his . . . , what did he do or take for this condition? Anything else? Write in _____			
20a. Does --- NOW take any medicine or treatment for his . . . ?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (21)	
b. Was any of this medicine or treatment recommended by a doctor?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
21. Has he EVER had surgery for this condition?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
22. Has he EVER been hospitalized for this condition?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
23. During the past 12 months, about how many times has --- seen or talked to a doctor about his . . . ?		___ Times 000 <input type="checkbox"/> None	
24. About how many days during the past 12 months, has this condition kept him in bed all or most of the day?		___ Days 000 <input type="checkbox"/> None	
25a. How often does his . . . bother him - all of the time, some of the time, or never? (Mark one box)		If bothered at all, ask 25b. If not bothered, go to 25c.	
1 <input type="checkbox"/> All the time (25b) 2 <input type="checkbox"/> Some time (25b) 0 <input type="checkbox"/> Never (25c) 3 <input type="checkbox"/> Other _____ (Specify)			
b. When it does bother him, is he bothered a great deal, some, or very little? (Mark one box)			
1 <input type="checkbox"/> Great deal (NC) 2 <input type="checkbox"/> Some (NC) 3 <input type="checkbox"/> Very little (NC) 4 <input type="checkbox"/> Other (Specify) _____ (NC)			
c. Does --- still have his . . . ?		1 <input type="checkbox"/> Yes (Next condition) <input type="checkbox"/> No (25d)	
d. Is this condition completely cured or is it under control?		2 <input type="checkbox"/> Cured (25e) 3 <input type="checkbox"/> Und. cont. (Next cond.) 4 <input type="checkbox"/> Other _____ (Specify) (Next Cond.)	
e. About how long did --- have this condition before it was cured?		0 <input type="checkbox"/> Less than one month ___ Months ___ Years	