

ARTHRITIS: CY 1969

FORM HIS-2A (1969) (12-3-68) U.S. DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS ACTING AS COLLECTING AGENT FOR THE U.S. PUBLIC HEALTH SERVICE U.S. HEALTH INTERVIEW SURVEY ARTHRITIS SUPPLEMENT	BUDGET BUREAU NO. 68-R1600 APPROVAL EXPIRES MARCH 31, 1970			
	PSU	Segment	Serial No.	Sample B-
	Name of sample person			Person No.
Name of interviewer	Code	1 <input type="checkbox"/> Responded for 'self OR Person number of respondent →		
Footnotes				
NOTICE - All information which would permit identification of the individual will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purpose.				

<p>Earlier in the interview you told me about ---'s arthritis (rheumatism, . . .). This is a matter of special interest to the U.S. Public Health Service, and I have some additional questions about it.</p>	<p>Starting time . . .</p>	<p>a.m. _____ p.m.</p>
<p>1a. During the past 12 months, have you had any STIFFNESS in your joints when first getting out of bed in the morning?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No (2)</p>
<p>b. What time of day does this stiffness usually go away?</p>	<p>_____ a.m. _____ p.m.</p>	<p><input type="checkbox"/> Never</p>
<p>c. During the past 12 months, have your WRISTS been stiff when first getting out of bed in the morning?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>
<p>2a. During the past 12 months, have you had PAIN in your joints when moving them?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No (3)</p>
<p>b. During that period, have your WRISTS been painful when you moved them?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>
<p>3a. (During the past 12 months) have you had SWELLING in any joints except in the ankles or feet?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No (4)</p>
<p>b. During that period, have you had any swelling in your WRISTS?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>
<p>4a. (During the past 12 months) have you had PAIN or SORENESS when you touch or press on your joints?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No (5)</p>
<p>b. During that period, have you had any pain or soreness when you touched or pressed on your WRISTS?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No</p>
<p>If "Yes" in questions 1c, 2b, 3b, or 4b ask:</p>		
<p>5. Which wrist is bothered or affected by arthritis?</p>	<p>1 <input type="checkbox"/> Right</p>	<p>2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>
<p>6a. During the past 12 months, have any of the joints in your FINGERS been bothered or affected by arthritis?</p>	<p>1 <input type="checkbox"/> Yes</p>	<p>2 <input type="checkbox"/> No (7)</p>
<p>b. Please look at this picture of a hand. (HAND CARD D TO RESPONDENT) Tell me what colors on this card match the joints of your RIGHT hand that are bothered or affected by arthritis.</p>	<p><input type="checkbox"/> 1 Red <input type="checkbox"/> 2 Blue <input type="checkbox"/> 3 Yellow</p>	<p><input type="checkbox"/> 4 Gray <input type="checkbox"/> None</p>
<p>c. Now your LEFT hand. What colors match the joints of your LEFT hand that are bothered or affected by arthritis?</p>	<p><input type="checkbox"/> 1 Red <input type="checkbox"/> 2 Blue <input type="checkbox"/> 3 Yellow</p>	<p><input type="checkbox"/> 4 Gray <input type="checkbox"/> None</p>
<p>d. Are you right-handed or left-handed?</p>	<p>1 <input type="checkbox"/> Right</p>	<p>2 <input type="checkbox"/> Left 3 <input type="checkbox"/> Both</p>
<p>Footnotes</p>		

7a. During the past 12 months, have your ELBOWS been bothered or affected in any way by arthritis?	<input type="checkbox"/> Yes 1 <input type="checkbox"/> No (8)																																							
b. Which elbow is affected?	2 <input type="checkbox"/> Right 3 <input type="checkbox"/> Left 4 <input type="checkbox"/> Both																																							
8a. During the past 12 months, have your KNEES been affected in any way by arthritis?	<input type="checkbox"/> Yes 1 <input type="checkbox"/> No (9)																																							
b. Which knee is affected?	2 <input type="checkbox"/> Right 3 <input type="checkbox"/> Left 4 <input type="checkbox"/> Both																																							
9a. Do you presently have pain, swelling, or stiffness in any joint as a result of an old accident or injury?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (10)																																							
b. Did this accident or injury happen during the past 12 months or before that time?	1 <input type="checkbox"/> During past 12 months (10) 2 <input type="checkbox"/> More than 12 months ago																																							
c. Which joints were hurt in this accident or injury?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"></td> <td style="width: 10%; text-align: center;">Right</td> <td style="width: 10%; text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Upper back</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Middle back</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Lower back</td> <td></td> <td></td> </tr> <tr> <td> Ankle . . .</td> <td></td> <td></td> </tr> <tr> <td> Elbow . . .</td> <td></td> <td></td> </tr> <tr> <td> Foot . . .</td> <td></td> <td></td> </tr> <tr> <td> Hand . . .</td> <td></td> <td></td> </tr> <tr> <td> Hip . . .</td> <td></td> <td></td> </tr> <tr> <td> Knee . . .</td> <td></td> <td></td> </tr> <tr> <td> Shoulder</td> <td></td> <td></td> </tr> <tr> <td> Wrist . . .</td> <td></td> <td></td> </tr> </table>		Right	Left	<input type="checkbox"/> Neck			<input type="checkbox"/> Upper back			<input type="checkbox"/> Middle back			<input type="checkbox"/> Lower back			Ankle . . .			Elbow . . .			Foot . . .			Hand . . .			Hip . . .			Knee . . .			Shoulder			Wrist . . .		
	Right	Left																																						
<input type="checkbox"/> Neck																																								
<input type="checkbox"/> Upper back																																								
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<input type="checkbox"/> Lower back																																								
Ankle . . .																																								
Elbow . . .																																								
Foot . . .																																								
Hand . . .																																								
Hip . . .																																								
Knee . . .																																								
Shoulder																																								
Wrist . . .																																								
10. Who was the FIRST person to tell you that you had arthritis?	1 <input type="checkbox"/> Medical doctor 2 <input type="checkbox"/> Chiropractor 3 <input type="checkbox"/> Friend 4 <input type="checkbox"/> Relative <input type="checkbox"/> Other (Specify) _____																																							
11. When did a doctor first tell you that you had arthritis?	0 <input type="checkbox"/> Less than 12 months ago 8 <input type="checkbox"/> Doctor never said it was arthritis ____ Years 9 <input type="checkbox"/> Doctor never seen																																							
12. When did your arthritis bother you the most—during the past 12 months, when you first noticed it, or at some other time?	1 <input type="checkbox"/> During the past 12 months 2 <input type="checkbox"/> When first noticed it. 3 <input type="checkbox"/> Some other time																																							
13. Have you ever been treated by any of the following people for your ARTHRITIS —																																								
a. a foot doctor (chiroprapist or podiatrist)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																							
b. a physical therapist?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																							
c. an occupational therapist?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																							
14a. Have you ever seen a social worker for your arthritis?	<input type="checkbox"/> Yes 1 <input type="checkbox"/> No (15)																																							
b. Was the social worker from a hospital?	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No																																							

15. Have you EVER used (any of the following) for your arthritis -		TABLE I	
		Are you now using -- for your arthritis? (1)	(2)
a. Any splints or casts?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (b)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No (b)	Where are the splints or casts worn? (Specify)
b. Braces of any kind?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (c)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No (c)	Where are the braces worn? (Specify)
c. Diathermy or paraffin?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (d)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No	
d. Hot packs, hot baths, or a heating pad?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (e)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No	
e. Cold packs or ice treatment?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (f)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No	
f. Rest recommended by a doctor?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (g)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No	
g. Exercises recommended by a doctor or physical therapist?	1 <input type="checkbox"/> Yes → <input type="checkbox"/> No (h)	2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> No	
16a. Are you now taking Aspirin, Anacin, or Bufferin for your arthritis?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)	
b. Do you take it every day?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (17)	
c. About how many do you usually take each day?		___ Number per day	
d. Do you usually take the same amount every day?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
e. How long have you been taking aspirin every day?		0 <input type="checkbox"/> Less than one month ___ Months ___ Years	
17a. Are you presently taking any injections or shots for your arthritis?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (18)	
b. Are any of these injections "gold" shots?		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Footnotes			

18a. Are you presently taking any (other) drugs or medicines that were recommended by a medical doctor for your arthritis? <hr/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (19)
b. What are the names of these medicines? →	1 <input type="checkbox"/> Butazolidin, Sterazolidin, Tandearil 2 <input type="checkbox"/> Aristocort, Cortisone, Decadron, Medrol, Prednisone 4 <input type="checkbox"/> Darvon, Soma, Tylenol <input type="checkbox"/> Other _____ <div style="text-align: right;"><i>(Specify)</i></div>
19a. Have you EVER used any remedies or medicines for your arthritis either on your own or that were recommended by someone OTHER than a medical doctor?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (20)
b. What kind of remedies or medicines did you use? <i>(Enter name or description of remedies or medicines in column (a) of Table II below.)</i>	
c. Anything else?	<input type="checkbox"/> Yes (Reask (19b)) <input type="checkbox"/> No

TABLE II

Remedies or medicines (a)	Have you used -- at any time during the past 12 months? (b)	Did you ever talk to a medical doctor about using --? (c)
1.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
2.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
3.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
4.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
5.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
6.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
7.	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

Footnotes

Some people need help because of arthritis--		For each "Yes" answer, ask: What kind of help is this -- a person or some kind of aid?	
20. Do you use the help of another person or special aid--			
(a) when getting in or out of an automobile? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No (b)		2 <input type="checkbox"/> Person	3 <input type="checkbox"/> Aid
(b) when going up or down stairs? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No (c)		2 <input type="checkbox"/> Person	3 <input type="checkbox"/> Aid
(c) when getting in or out of a tub or shower? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No (d)		2 <input type="checkbox"/> Person	3 <input type="checkbox"/> Aid
Do you use the help of another person or special aid--			
(d) in order to completely dress yourself? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No (e)		2 <input type="checkbox"/> Person	3 <input type="checkbox"/> Aid
(e) in order to feed yourself a complete meal? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No (f)		2 <input type="checkbox"/> Person	3 <input type="checkbox"/> Aid
(f) when rolling onto your side in bed? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No (21)		2 <input type="checkbox"/> Person	3 <input type="checkbox"/> Aid
21a. Does your ARTHRITIS cause you to sit or lie down to rest at any time during the day?		1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No (e)
b. At what time do you usually sit or lie down to rest?		Time _____	a.m. p.m.
c. Do you rest some every day?		1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No (e)
d. How long do you usually rest each day?		Hours _____	Minutes _____
e. What time do you USUALLY get up in the morning?		Time _____	a.m.
Footnotes			

22a. Are you PRESENTLY seeing anyone for your arthritis? 1 Yes (c) 2 No (b)

b. Could you tell me why you aren't presently seeing anyone for your arthritis?

1 Arthritis not severe enough (23) Other (Record response verbatim) _____ (23)

2 No one can do anything for it (23)

c. Who are you seeing?
d. Are you now seeing anyone else for your arthritis?

} Check all categories in Table III that apply. Then ask the appropriate questions for each category marked.

TABLE III			
Type of person	<input type="checkbox"/> Medical doctor	<input type="checkbox"/> Medical doctor	<input type="checkbox"/> Other (Specify) ↗
1. What is the name and address of the doctor you see?	Name and address	Name and address	_____
2. Why did you decide to go to this --- for your arthritis?	1 <input type="checkbox"/> He's a family doctor 2 <input type="checkbox"/> Referred by doctor 3 <input type="checkbox"/> Referred by someone else 4 <input type="checkbox"/> He's an arthritis specialist <input type="checkbox"/> Other (Specify) ↗ _____	1 <input type="checkbox"/> He's a family doctor 2 <input type="checkbox"/> Referred by doctor 3 <input type="checkbox"/> Referred by someone else 4 <input type="checkbox"/> He's an arthritis specialist <input type="checkbox"/> Other (Specify) ↗ _____	1 <input type="checkbox"/> He's a family doctor 2 <input type="checkbox"/> Referred by doctor 3 <input type="checkbox"/> Referred by someone else 4 <input type="checkbox"/> He's an arthritis specialist <input type="checkbox"/> Other (Specify) ↗ _____
3a. Is the doctor a general practitioner or a specialist?	1 <input type="checkbox"/> General practitioner (4) <input type="checkbox"/> Specialist	1 <input type="checkbox"/> General practitioner (4) <input type="checkbox"/> Specialist	
b. What kind of specialist is he?			
4. When was the LAST time you saw --- for your arthritis?	1 <input type="checkbox"/> Past 2 weeks ____Weeks ____Months	1 <input type="checkbox"/> Past 2 weeks ____Weeks ____Months	1 <input type="checkbox"/> Past 2 weeks ____Weeks ____Months
5. Where did you see the ---, at his office, your home, or some other place?	1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Home (Next column) <input type="checkbox"/> Other (Specify) ↗ _____	1 <input type="checkbox"/> Doctor's office 2 <input type="checkbox"/> Home (Next column) <input type="checkbox"/> Other (Specify) ↗ _____	2 <input type="checkbox"/> Home (Stop) <input type="checkbox"/> Other (Specify) ↗ _____
6. About how long did it take you to get to the ---?	____Minutes ____Hours	____Minutes ____Hours	____Minutes ____Hours
7. How did you get to and from the ---?	1 <input type="checkbox"/> Bus or subway 2 <input type="checkbox"/> Taxi 3 <input type="checkbox"/> Private car <input type="checkbox"/> Other (Specify) ↗ _____	1 <input type="checkbox"/> Bus or subway 2 <input type="checkbox"/> Taxi 3 <input type="checkbox"/> Private car <input type="checkbox"/> Other (Specify) ↗ _____	1 <input type="checkbox"/> Bus or subway 2 <input type="checkbox"/> Taxi 3 <input type="checkbox"/> Private car <input type="checkbox"/> Other (Specify) ↗ _____

23a. Have you ever had any special job training because of your arthritis?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (24)
b. Where did you receive this training?	Name of place
24a. Have you ever changed or left a job because of your arthritis?	1 <input type="checkbox"/> Yes (c) 2 <input type="checkbox"/> No
b. Have you worked at any time since you had arthritis— (For females add: not counting work around the house)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (25)
c. In general has your own income decreased because of your arthritis?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25a. Have you ever heard of the Arthritis Foundation?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (STOP) 3 <input type="checkbox"/> Don't know (STOP)
b. How did you first learn about the Arthritis Foundation?	Describe
c. Have you ever received any personal help, treatment, referral, or other information from the Arthritis Foundation?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (STOP)
d. What did the Arthritis Foundation do for you?	Describe
Footnotes	Ending time _____ a.m. _____ p.m.