

CONDITION PAGE 1	1. Person number	Name of condition																															
Enter person number and "Name of condition."	_____	_____																															
Ask for all conditions	2. Did <u> </u> ever at any time talk to a doctor about his . . . ?																																
Examine "Name of condition" entry in item 1 and mark	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No <input type="checkbox"/> Accident or injury (4) <input type="checkbox"/> On Card C (10) <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?																																
Do not ask for Cancer or Arthritis	b. What was the cause of . . . ? <input type="checkbox"/> Accident or injury (4)																																
If the entry in 3a or 3b includes the words:	c. What kind of . . . is it?																																
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Arthritis</td> <td style="width: 25%;">Measles</td> <td style="width: 25%;">Ailment</td> <td style="width: 25%;">Disease</td> <td rowspan="5" style="font-size: 2em; vertical-align: middle;">} Ask!</td> </tr> <tr> <td>Asthma</td> <td>Rupture</td> <td>Attack</td> <td>Disorder</td> </tr> <tr> <td>Cyst</td> <td>Tumor</td> <td>Condition</td> <td>Trouble</td> </tr> <tr> <td>Growth</td> <td>Ulcer</td> <td>Defect</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Arthritis	Measles	Ailment	Disease	} Ask!	Asthma	Rupture	Attack	Disorder	Cyst	Tumor	Condition	Trouble	Growth	Ulcer	Defect						d. How does the allergy (stroke) affect him?											
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For allergy or stroke, ask:	e. What part of the body is affected? (Specify) _____																																
For any entry that includes the words:	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																																
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Abscess</td> <td style="width: 25%;">Damage</td> <td style="width: 25%;">Paralysis</td> <td rowspan="10" style="font-size: 2em; vertical-align: middle;">} Ask!</td> </tr> <tr> <td>Ache (except headache)</td> <td>Growth</td> <td>Rupture</td> </tr> <tr> <td>Bleeding</td> <td>Hemorrhage</td> <td>Sore</td> </tr> <tr> <td>Blood clot</td> <td>Infection</td> <td>Soreness</td> </tr> <tr> <td>Boil</td> <td>Inflammation</td> <td>Tumor</td> </tr> <tr> <td>Cancer</td> <td>Neuralgia</td> <td>Ulcer</td> </tr> <tr> <td>Cramps (except menstrual)</td> <td>Neuritis</td> <td>Varicose veins</td> </tr> <tr> <td>Cyst</td> <td>Pain</td> <td>Weak</td> </tr> <tr> <td></td> <td>Palsy</td> <td>Weakness</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Abscess	Damage	Paralysis	} Ask!	Ache (except headache)	Growth	Rupture	Bleeding	Hemorrhage	Sore	Blood clot	Infection	Soreness	Boil	Inflammation	Tumor	Cancer	Neuralgia	Ulcer	Cramps (except menstrual)	Neuritis	Varicose veins	Cyst	Pain	Weak		Palsy	Weakness					
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FILL QUESTIONS 4-9 FOR ALL ACCIDENTS OR INJURIES

<p>4a. Did the accident happen during the past 2 years or before that time? <input type="checkbox"/> During the past 2 years (4b) <input type="checkbox"/> Before 2 years (5a)</p> <p>b. When did the accident happen? <input type="checkbox"/> Last week <input type="checkbox"/> 3-12 months <input type="checkbox"/> Week before <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2 weeks-3 months</p> <p>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?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Part(s) of body</td> <td style="width:50%;">Kind of injury</td> </tr> <tr> <td> </td> <td> </td> </tr> </table> <p>If accident happened BEFORE 3 months, ask: b. What part of the body is affected now? How is his -- affected? Is he affected in any other way?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Part(s) of body</td> <td style="width:50%;">Present effects</td> </tr> <tr> <td> </td> <td> </td> </tr> </table> <p>6a. Was a car, truck, bus, or other motor vehicle involved in the accident in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No (7)</p> <p>b. Was more than one vehicle involved? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Was it (either one) moving at the time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Part(s) of body	Kind of injury			Part(s) of body	Present effects			<p>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)</p> <p>8. Was -- at work at his job or business when the accident happened? 1 <input type="checkbox"/> Yes <input type="checkbox"/> While in Armed Services 2 <input type="checkbox"/> No <input type="checkbox"/> Under 17 at time of accident</p> <p>Ask for all accidents that happened during the past 2 weeks except those involving moving motor vehicles.</p> <p>9. We are interested in the objects that caused this accident and injury. How did the accident happen?</p> <p>Footnotes</p>
Part(s) of body	Kind of injury								
Part(s) of body	Present effects								
<p>10. <input type="checkbox"/> Not an eye cond. (11) <input type="checkbox"/> First eye cond. (10a) <input type="checkbox"/> Under 6 (11) <input type="checkbox"/> Not first eye cond. (11)</p> <p>10a. Can -- see well enough to read ordinary newspaper print with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>11. 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 (16a)</p> <p>12. During that period, how many days did he cut down for as much as a day? ___ Days 00 <input type="checkbox"/> None (16a)</p> <p>13. 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</p> <p>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 (16a) 00 <input type="checkbox"/> None (16a)</p> <p>15. Ask if 6-16 years: How many days did his ... keep him from school during that 2-week period? ___ Days 00 <input type="checkbox"/> None</p> <p>16a. When did he first notice his ...? - Was it during the past 3 months or before that time? <input type="checkbox"/> During 3 mos. <input type="checkbox"/> More than 3 mos. ago (17)</p> <p>b. Did he first notice it during the past two weeks or before that time? <input type="checkbox"/> Past 2 weeks <input type="checkbox"/> More than 2 wks. ago (AA)</p> <p>c. Which week, last week or the week before? 1 <input type="checkbox"/> Last week } (AA) 2 <input type="checkbox"/> Week before }</p> <p>17. 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</p>								
<p>AA Continue if { reported in probe Q. 17, 28 or 36 or Card A } otherwise, go to next condition { Do not continue for missing extremities }</p>									
<p>INTERVIEWER CHECK ITEM <input type="checkbox"/> Doctor seen (19) <input type="checkbox"/> Doctor not seen (18)</p>									
<p>18. During the past 12 months what did -- do or take for his ...? Anything else? Write in _____ (25)</p>									
<p>19. After -- first noticed something was wrong, about how long was it before he talked to a doctor about it? (Probe: Was it a matter of days, weeks, or months?) 0 <input type="checkbox"/> Discovered by doctor (21) 2 ___ Days 4 ___ Months 3 ___ Weeks 5 ___ Years</p>									
<p>20. Before -- talked to a doctor about his ... , what did he do or take for this condition? Anything else? Write in _____ 0 <input type="checkbox"/> Nothing</p>									
<p>21a. Does -- NOW take any medicine or treatment for his ... ? <input type="checkbox"/> Yes <input type="checkbox"/> No (22)</p> <p>b. Was any of this medicine or treatment recommended by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>									
<p>22. Has he ever had surgery for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>									
<p>23. Was he ever hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>									
<p>24. During the past 12 months, about how many times has -- seen or talked to a doctor about his ... ? (Do not count visits while a patient in a hospital.) ___ Times 000 <input type="checkbox"/> None</p>									
<p>25. 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</p>									
<p>26a. How often does his ... bother him - all of the time, often, once in a while, or never? 1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Often 3 <input type="checkbox"/> Once in a while 4 <input type="checkbox"/> Never (26c) 4 <input type="checkbox"/> Other _____ (Specify) (26b)</p>									
<p>b. When it does bother him, is he bothered a great deal, some, or very little? 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)</p>									
<p>c. Does -- still have his ... ? <input type="checkbox"/> Yes (Next condition) <input type="checkbox"/> No (26d)</p>									
<p>d. Is this condition completely cured or is it under control? _____ (NC) <input type="checkbox"/> Cured (26e) <input type="checkbox"/> Und. cont. (NC) <input type="checkbox"/> Other (Specify) _____</p>									
<p>e. About how long did -- have this condition before it was cured? 0 <input type="checkbox"/> Less than one month ___ Months ___ Years</p>									