

ITEM A

Please list below the names of each family member NOW living at home beginning with the Head of the family.

Names of Family Members	Relationship to Family Head	Sex (Check one)	Person's age on last birthday:
1. _____	Head	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
2. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
3. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
4. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
5. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
6. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
7. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
8. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
9. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old
10. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ years old

Are any family members now living at this household on full-time active duty with the Armed Forces of the United States?

(Check one box)

No

Yes

Who is this?

_____ Name of Family Member

_____ Name of Family Member

What is the highest grade or year the HEAD of the family completed in school?

(Circle one) Elementary: 1 2 3 4 5 6 7 8
High School: 9 10 11 12
College: 1 2 3 4 5+

ITEM B

Besides the family members that you have listed above, is there anyone else living with you now, such as friends or roomers?

(Check one box)

No (Go to next page)

Yes

Please list below the name of each person not related to you who is now living at this household.

Names of Other Persons

1. _____
2. _____
3. _____
4. _____
5. _____

The term "THIS FAMILY" in each of the questions on the following pages refers to all members of your family that you have listed in Item A on the page to the left.

HEALTH INSURANCE

1. During 1970, that is, from January 1, 1970, to December 31, 1970, how much did THIS FAMILY spend on health insurance premiums for plans that pay for any part of a hospital bill or a doctor's bill?

DOLLARS	CENTS
or	
<input type="checkbox"/> This family did not pay any insurance premiums	

Include:

- Amount deducted from paycheck for health insurance premiums
- Amount deducted from Social Security check for Medicare
- Amount paid directly to health insurance plans or to Social Security for Medicare

Do not include:

- Health insurance plans that pay only in the case of accidents
- Employer or union contributions

PAYMENTS MADE FOR PERSONS NOT LISTED IN ITEM A ON THIS QUESTIONNAIRE

2. During 1970, did THIS FAMILY pay any medical expenses for any person who is NOT listed in Item A on the page to the left?

This might include expenses for children now away at school or parents, other relatives or friends now in nursing homes or elsewhere, or who are deceased.

These expenses may include bills from doctors, dentists, optometrists, hospitals, nursing homes, health insurance premiums, cost of prescription medicine, eye glasses, and so forth.

(Check one box)

- No Yes

TYPE OF MEDICAL EXPENSE

Amount This Family Paid

DOLLARS	CENTS
\$	
DOLLARS	CENTS
\$	
DOLLARS	CENTS
\$	

3. What income group best describes THIS FAMILY'S total combined income during 1970?

(Check one box)

- | | |
|--|--|
| <input type="checkbox"/> Less than \$3,000 | <input type="checkbox"/> \$7,000 - \$9,999 |
| <input type="checkbox"/> \$3,000 - \$4,999 | <input type="checkbox"/> \$10,000 - \$14,999 |
| <input type="checkbox"/> \$5,000 - \$6,999 | <input type="checkbox"/> \$15,000 - \$24,999 |
| | <input type="checkbox"/> \$25,000+ |

4. Please print below the name of the person or persons who are completing this form.

Name _____

Name _____

FILL ONE PAGE FOR EACH FAMILY MEMBER NOW LIVING IN THIS HOUSEHOLD WRITE IN THE PERSON'S NAME BELOW BEFORE ANSWERING THE QUESTIONS ABOUT HIM:

The following medical and dental expenses were for _____
Write in Name of Family Member

All questions on this page should be answered even though the person may not have had any medical or dental expenses in 1970. If the person did not have any expense of a certain kind during 1970, be sure to make a mark in the "no bills paid" box. The amounts you give below should only include what THIS FAMILY paid, NOT any payments made by health insurance or some other person or agency. Do not include payments you made if health insurance has or will reimburse you. IF EXACT AMOUNTS ARE NOT KNOWN, PLEASE ENTER YOUR BEST ESTIMATE.

DENTAL BILLS PAID

1. How much did THIS FAMILY spend on dental bills for this person during 1970, that is, from January 1, 1970, to December 31, 1970?

INCLUDE amounts spent for:
 Cleanings Straightening Dental surgery Bridgework Other services from a
 Fillings X-rays Extractions Dental laboratory fees dentist or hygienist

DOLLARS	CENTS
\$	
or	
<input type="checkbox"/> No dental bills paid for this person	

DOCTORS' BILLS PAID

2. How much did THIS FAMILY spend on doctor bills for this person during 1970?

INCLUDE amounts spent for:
 Routine doctor visits Doctor fees while a Deliveries Shots
 Treatments patient in a hospital Pregnancy care Other services by a
 Check-ups Operations Laboratory fees medical doctor

DOLLARS	CENTS
\$	
or	
<input type="checkbox"/> No doctor bills paid for this person	

HOSPITAL BILLS PAID

3. How much did THIS FAMILY spend on hospital bills for this person during 1970?

INCLUDE amounts spent for:
 Room and board Anesthesia Special treatments
 Operating and Tests Any other hospital services
 delivery rooms X-rays

DOLLARS	CENTS
\$	
or	
<input type="checkbox"/> No hospital bills paid for this person	

PAYMENTS MADE FOR PRESCRIPTION MEDICINE

4. About how much did THIS FAMILY spend on medicine for this person during 1970 that was purchased on a DOCTOR'S OR DENTIST'S PRESCRIPTION?

INCLUDE amounts spent for:
 Medicines only if they were prescribed by a doctor or dentist

DOLLARS	CENTS
\$	
or	
<input type="checkbox"/> No prescribed medicines bought for this person	

PAYMENTS MADE FOR EYEGLASSES, CONTACT LENSES OR OPTOMETRIST'S BILLS

5. During 1970 how much did THIS FAMILY spend on eyeglasses, contact lenses, or optometrists' fees for this person?

DOLLARS	CENTS
\$	
or	
<input type="checkbox"/> No amount paid for these items	

PAYMENTS MADE FOR "OTHER" MEDICAL BILLS

6a. How much did THIS FAMILY spend on other medical expenses for this person during 1970?

Do not include any expenses which you have already recorded. Do not include amounts spent for medicines of any kind.

INCLUDE amounts spent for such expenses as:
 Chiropractors' or Podiatrists' fees Physical or Speech Therapy
 Hearing aid Special nursing care
 Special braces, trusses, wheelchair Nursing Home or Convalescent
 or artificial limbs Home care

DOLLARS	CENTS
\$	
or	
<input type="checkbox"/> No amount paid for these items	

6b. What type of medical expense did this person have?

_____ Type of Medical Expense

7. Check one of the following boxes:

- Referred to records for all dollar amounts entered on this page.
- Referred to records for some but not all dollar amounts entered on this page.
- Did not refer to any records.