

<b>BD</b>	Mark box(es) from item C.	<b>BD</b> 1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days
<b>45. During the past 12 months (that is since _____ (date) a year ago), ABOUT how many days did illness or injury keep -- in bed all or most of the day?</b> (Include the days in the past 2 weeks.) (Include the days while a patient in a hospital.) (Was it more than 7 days or less than 7 days?) (Was it more than 30 days or less than 30 days?) (Was it more than half the year or less than half the year?)		<b>45.</b> 0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)

Table SA																																											
46a. Does anyone in the family now use (any of the following special aids) -	Yes	No																																									
1. An artificial arm? .....			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Person No.</th> <th style="width: 10%;">Type of aid</th> <th style="width: 20%;">If 1-6 in (b), ASK: Does he use one or two (at a time)?</th> <th style="width: 60%;">If 3-10 in (b), ASK: For what condition does he need this? (Item C) If "brace," Ask: On what part of the body is the brace worn? (d)</th> </tr> <tr> <th>(a)</th> <th>(b)</th> <th>(c)</th> <th></th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> <tr> <td></td> <td></td> <td>1 <input type="checkbox"/> 2 <input type="checkbox"/> Other</td> <td></td> </tr> </tbody> </table>	Person No.	Type of aid	If 1-6 in (b), ASK: Does he use one or two (at a time)?	If 3-10 in (b), ASK: For what condition does he need this? (Item C) If "brace," Ask: On what part of the body is the brace worn? (d)	(a)	(b)	(c)				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other				1 <input type="checkbox"/> 2 <input type="checkbox"/> Other	
Person No.	Type of aid	If 1-6 in (b), ASK: Does he use one or two (at a time)?		If 3-10 in (b), ASK: For what condition does he need this? (Item C) If "brace," Ask: On what part of the body is the brace worn? (d)																																							
(a)	(b)	(c)																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
		1 <input type="checkbox"/> 2 <input type="checkbox"/> Other																																									
2. An artificial leg? .....																																											
3. A brace of any kind? .....																																											
4. Crutches? .....																																											
5. A cane or walking stick? .....																																											
6. Special shoes? .....																																											
7. A wheel chair? .....																																											
8. A walker? .....																																											
9. Guide dog? .....																																											
10. Any other kind of aid for getting around? .....																																											
<i>If "Yes," specify:</i> _____ <div style="text-align: center;">Enter in Table SA</div>																																											
<b>b. Who is this?</b> <b>c. Anyone else?</b>																																											

FOOTNOTES

1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days	<b>BD</b>	1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days	1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days	<b>BD</b>	1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days	1 <input type="checkbox"/> 1+ Bed Days 2 <input type="checkbox"/> 1+ Hospital Stays 3 <input type="checkbox"/> No Bed Days
0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)	45.	0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)	0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)	45.	0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)	0 <input type="checkbox"/> None 1 <input type="checkbox"/> 1-7 2 <input type="checkbox"/> 8-30 3 <input type="checkbox"/> 31-180 (6 months) 4 <input type="checkbox"/> 181+ (6 months +)

Table SA - Continued

Is the _____ used all of the time, most of the time or only occasionally? (e)	How long has he used _____? (f)	How was the _____ obtained? Was it purchased, rented, borrowed or a gift? (g)
1 <input type="checkbox"/> All    2 <input type="checkbox"/> Most    3 <input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than 1 month ____ Months    ____ Years	1 <input type="checkbox"/> Purchased    2 <input type="checkbox"/> Rented    3 <input type="checkbox"/> Borrowed    4 <input type="checkbox"/> Gift
1 <input type="checkbox"/> All    2 <input type="checkbox"/> Most    3 <input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than 1 month ____ Months    ____ Years	1 <input type="checkbox"/> Purchased    2 <input type="checkbox"/> Rented    3 <input type="checkbox"/> Borrowed    4 <input type="checkbox"/> Gift
1 <input type="checkbox"/> All    2 <input type="checkbox"/> Most    3 <input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than 1 month ____ Months    ____ Years	1 <input type="checkbox"/> Purchased    2 <input type="checkbox"/> Rented    3 <input type="checkbox"/> Borrowed    4 <input type="checkbox"/> Gift
1 <input type="checkbox"/> All    2 <input type="checkbox"/> Most    3 <input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than 1 month ____ Months    ____ Years	1 <input type="checkbox"/> Purchased    2 <input type="checkbox"/> Rented    3 <input type="checkbox"/> Borrowed    4 <input type="checkbox"/> Gift
1 <input type="checkbox"/> All    2 <input type="checkbox"/> Most    3 <input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than 1 month ____ Months    ____ Years	1 <input type="checkbox"/> Purchased    2 <input type="checkbox"/> Rented    3 <input type="checkbox"/> Borrowed    4 <input type="checkbox"/> Gift